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The Future Use of Pharmacy Supportive Personnel
Robert K. Chalmers

Medicaid Regulations and Guidelines for Pharmacy

Beclomethasone Dipropionate
Thomas C. Majerus

Attend Annual Swain Pharmacy Seminar

"Regulatory Agencies and the Pharmacist"
Quality Inn, Towson
Thursday, March 17, 1977

THE MARYLAND PHARMACIST

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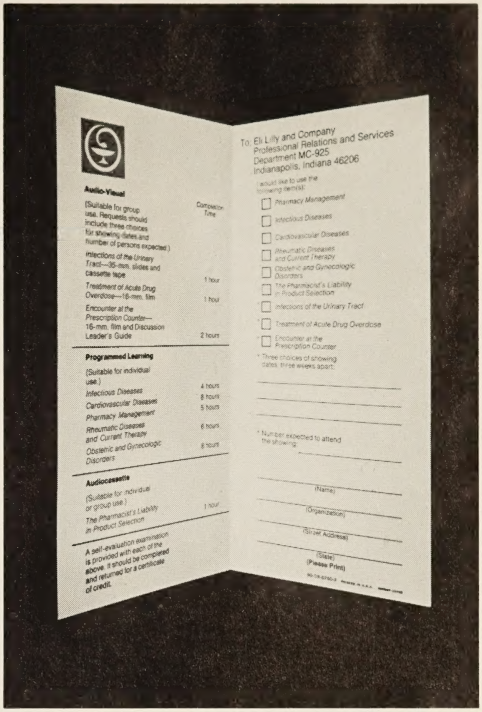

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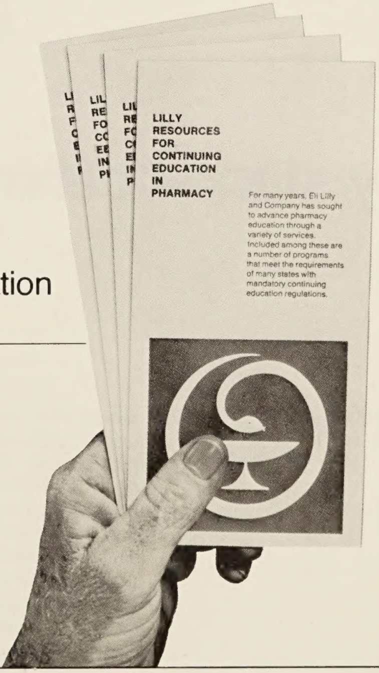

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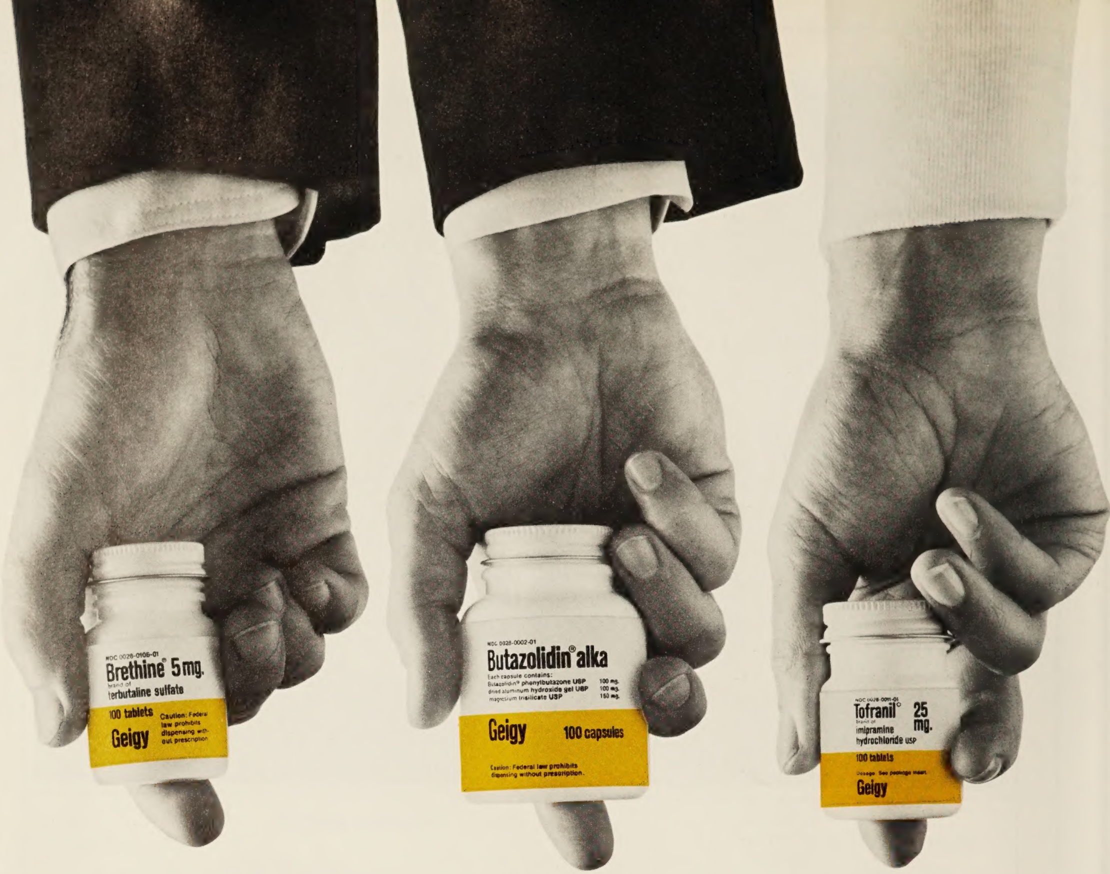
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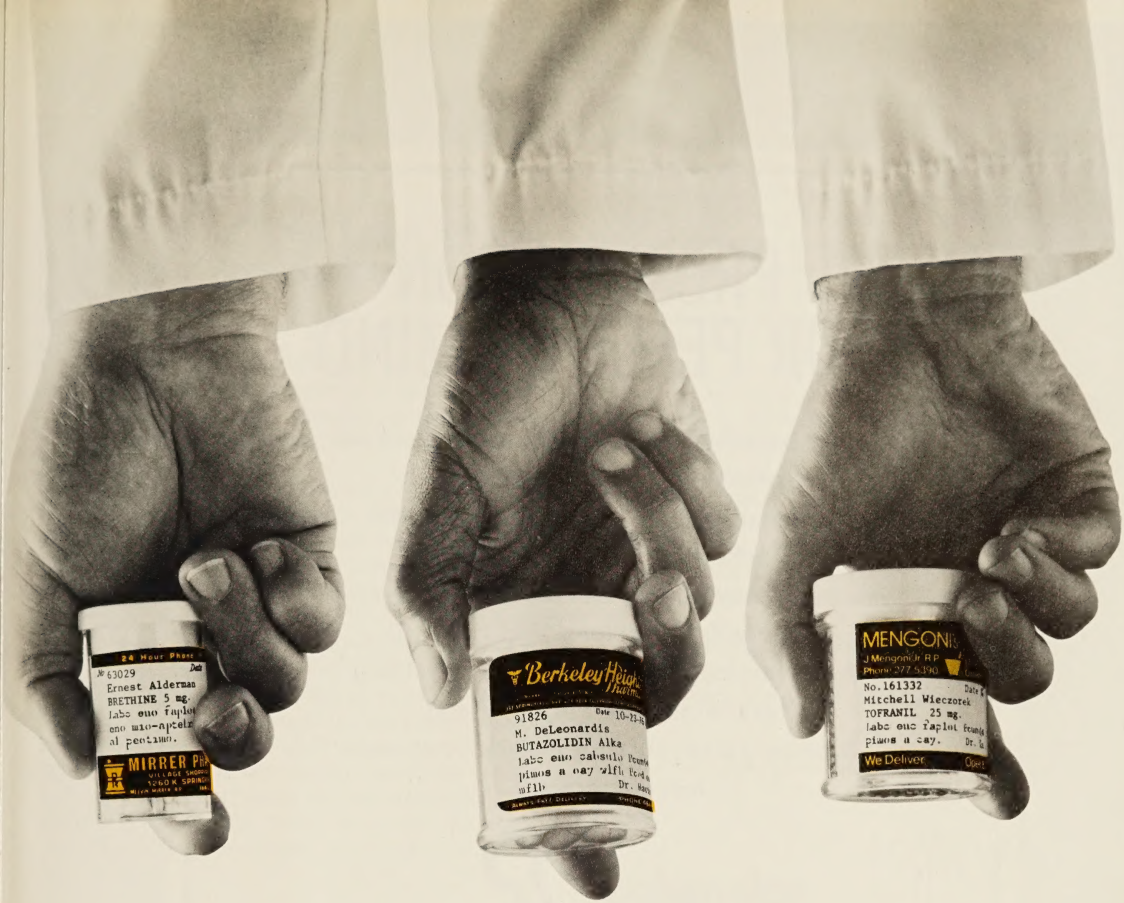
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editorial

"Unionizing" Not Legal Remedy For Prescription Fees

Pharmacists are becoming more and more involved in providing pharmacy services to patients covered by "third-party" prescription benefit programs. These various programs including their fees are presented on a "take-it-or-leave-it" basis.

Pharmaceutical associations have been able to meet with administrators to present the concerns of pharmacists about forms, processing and various grievances. MPhA has provided data about costs of operation, increases in expenses and information about other plans. These presentations have helped to show administrators of the need to adjust their compensation to meet constantly rising costs of operation and inflation.

However, except in the instances of governmental plans such as Medicaid, the Association is prohibited on pain of criminal violations and harsh penalties from negotiating about fees. In fact, no two individuals can act in concert about fees, threaten reprisals or conspire to plan and conduct boycotts. Every few years one or more pharmacists announces his discovery of a remedy: unionization.

The following memorandum was sent from Carl Roberts, Associate General Counsel of APhA, to William S. Apple, APhA Executive Director in response to Dr. Apple's request for further clarification regarding pharmacists' unionizing in order to negotiate with third parties without the constraint of anti-trust laws.

"You have referred to me a letter which recently appeared in a state association journal as an example of the recurring suggestion that pharmacists can avoid the impact of the antitrust laws and band together to negotiate fees in third-party payment programs by "unionizing." As I have previously advised you, and as we have indicated to individual APhA members who have requested information on this matter, the result suggested is legally incorrect.

"There is a recognized exemption from the 'price fixing' prohibitions of Section 1 of the Sherman Antitrust Act for 'labor organizations' (unions) when they engage in collective bargaining with employers with regard to 'wages, hours and working conditions' on behalf of employees they represent. I stress that the collective bargaining relationship must be between '*employers*' and '*labor organizations*' on behalf of '*employees.*'

"Pharmacists who participate in third-party payment programs are not 'employees' of those programs within the meaning of the National Labor Relations Act or the antitrust exemption. Rather, the relationship of the pharmacist to a third-party program is that of an 'independent contractor.' Independent contractors may not, through concerted group action, negotiate with third-party payment programs with regard to fees. For them to do so would bring them directly into conflict with the antitrust laws. The label they apply to such activity is not controlling.

"Frankly, I do not know what more APhA can do to effectively bring this understanding to every pharmacist in the country. We have provided this information in the past, but the 'theory' continues to be raised, and I expect will continue to be raised. Unfortunately, there is no way that the Association can protect every individual pharmacist or particular groups of pharmacists from their own ill-advised actions or misguided attitudes which stem from their lack of understanding of what the 'union' exemption precisely covers as a matter of law."

We trust that this information will lay the issue of unionization for this purpose to rest unless, of course, the antitrust laws of the land can be changed.

— Nathan I. Gruz

calendar

March 17 (Thursday) — MPhA Swain Seminar — Quality Court, Towson, "Regulatory Agencies and the Pharmacist."

March 20 (Sunday) — U. of M. School of Pharmacy Annual Alumni Dinner Meeting, Martins West

March 27-April 1 — International Symposium on Drug Activity, Jerusalem, Israel

March 28-30 — NARD National Legislative and Public Affairs Conference, Washington, D.C.

April 17 (Sunday) — AZO Fritz Berman Seminar, Holiday Inn, Baltimore Beltway Exit 17

April 21 (Thursday) — MPhA Regional and House of Delegates Meeting, Friendship International Hotel

May 15-19 — APhA Convention, New York City

June 2 (Thursday) — U. of M. School of Pharmacy Alumni Association Banquet, Eudowood Gardens

June 17-19 — MSHP Seminar, Sheraton Hotel, Ocean City, Maryland

June 19-22 — MPhA Annual Convention, Carousel Hotel, Ocean City, Maryland

The Future Use of Pharmacy Supportive Personnel *

by Robert K. Chalmers †

I wish to commend the Alumni Association of the University of Maryland School of Pharmacy and the Maryland Pharmaceutical Association for their decision to establish the Francis S. Balassone Memorial Lecture. Your decision to establish this event as a forum for open and frank discussion of issues of great concern to the profession is a fitting tribute to those principles which Frank Balassone represented. Frank Balassone was truly a leader with conviction and vision. It is indeed a pleasure and privilege to have the opportunity to help initiate this memorial event.

With respect to pharmacy supportive personnel (pharmacy technicians, pharmacy aides) where do you stand? What are your attitudes or convictions?

e.g., they are a needed component or they are a problem?

e.g., they are a means to further development of professional services or, if their use continues and their use is recognized they will be the end of professional service by pharmacists?

In other words, in what context, in what frame of reference, do you think of pharmacy supportive personnel? To extend that question, let me ask in what frame of reference do you view each of the many challenges and issues that we face in pharmacy: pharmacy supportive personnel, third party payment programs, prescription price posting, mandatory continuing education, medication records? Do you view them primarily in the context of the goals you are trying to achieve, in terms of the health-care needs you see to be served, or in terms of the problems you face and fear in your practice role and practice environment? What is the basis for your present views about pharmacy supportive personnel? Hopefully, you will feel open to share ideas and concerns in our discussion tonight.

In our profession, in so much of what we do in society today, we are *solution-oriented,* i.e., when presented with a problem we look for a simple or global solution that hopefully solves it (Dr. John Millis, Chairman of the Study Committee on Pharmacy, has presented a very interesting principle on this matter: "The trouble with most of our problems are our solutions"). Consider the "solutions" advocated by nearly all political candidates during the past campaign as they tried to win our support and votes. Consider the various "solutions" put forth to solve our health care problems today. Consider the various "solutions" posed to correct problems we face in pharmacy today: mandatory patient records, mandatory patient counseling, uniform professional degree, mandatory continuing education, drug-product selection, clinical pharmacy, third class of drugs, supportive personnel.

My point is not to denigrate any of the current "solutions" in the name of advancing our profession and the services we provide. My point is that none of these so-called solutions can really be an end in themselves. They cannot be considered in isolation from one another. A large part of pharmacy's problems today is the fragmentation or gaps we experience within the component steps of pharmacy education, within the component steps of pharmacy practice and between pharmacy and the other health professions. We must find ways to bridge these gaps and coordinate the component parts of pharmacy for greater efficiency and effectiveness. Hopefully we can accept the premise that none of the proposed solutions to pharmacy's problems can be considered alone as the total answer. The key in my mind when we discuss an issue in pharmacy, such as supportive personnel, is to put it into a larger context so we can have an opportunity to look frankly and objectively at the reasons for extreme viewpoints on this issue:

i.e., the strong reasons that some have for advocating specific training of and use of supportive personnel and recognition of that fact.

i.e., the strong reasons that others have for using supportive personnel but not recognizing formalized training as a prerequisite or corequisite to job entry.

i.e., the strong reasons that others have for not even using pharmacy supportive personnel by that or any other formalized name.

The reasons that we could identify for each of these stated positions, in their own right, provide compelling reasons for each of us to become lined up on one side or the other of this issue. This is again likened to a political campaign where each candidate presents his strongest arguments to put his position in the strongest light and discredit or point out major flaws in the position or the record of the opposition. In this way we are encouraged to make a clear choice between the candidates. With respect to problems in pharmacy we scarcely need this type of polarization on the issues. What we really need is to see an amalgamation, an accommodation of the views on all sides of a given issue. But, unless that particular approach is proposed as an alternative we also end up being forced to line up on one side or the other of each of the issues, or else we remain silent and sit on the fence letting the issue continue to fester or be "resolved" by others.

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*Presented at the Francis S. Balassone Memorial Lecture, November 18, 1976

†Dr. Chalmers is Associate Dean, Purdue University, School of Pharmacy, and Member, National Commission on Pharmacy.

What can we learn from recent history on another controversial topic that if applied to the supportive personnel issue might provide a *process* for progress? I refer to the issue of internship (apprenticeship or practical experience). Strong feelings on various sides of the issue were heard at NABP meetings, pharmacy association meetings, colleges, from students, from individual pharmacists. For years the issue festered until men like Frank Balassone identified a *process* which could help us bring together our fragmented views on the needs and the possible solutions to meet those needs. The *process* he worked for was to bring education, the boards of pharmacy, and the profession into a working relationship on the issue of the practical experience component of pharmacy students' education. The process, in our experience in Indiana and I'm certain your experience in Maryland, has not only improved the practical experience component of pharmacy students' education, it has also provided a means to facilitate valuable pharmacist input to the schools to identify more clearly the competencies needed of pharmacists for practice today. The result of this type of input has been positive refinements in our curriculum. This process has also provided ways for schools to become a valuable continuing resource to pharmacy practice to help effect evolutional improvements in patient-oriented pharmacy services.

For so long in pharmacy practice, in most components of society for that matter, we have been solution-oriented rather than process-oriented.

For so long in pharmacy practice, in most components of society for that matter, we have been *solution-oriented* rather than *process-oriented*. To the extent that pharmacy education and pharmacy practice are isolated from one another, we are not learning to work together and consequently, the process of education of pharmacy students cannot be optimally effective in helping students understand the set of circumstances and needs that exist in the real world of pharmacy practice and the real world of health care and of society in which practice must function. How does this relate to the issues concerning the use of supportive personnel in pharmacy? We need to identify a frame of reference within which the range of views about the pros and cons on the issue can be looked at critically and objectively. In such a way each of these views might contribute to the process of developing a consensus within the profession on the appropriate use of pharmacy supportive personnel to meet today's and tomorrow's needs in pharmacy.

The general practice of pharmacy will become increasingly recognized not only for its drug distribution and control responsibilities, but for informational services associated with the drug-therapy component that help optimize safe and effective use of drugs.

With respect to the training and utilization of pharmacy supportive personnel today and for the foreseeable future, let me list those factors about which I feel confident and will be willing to defend in the question and answer session. These will be presented in terms of the context of the needs that pharmacy services are or should be attempting to meet. Despite the many problems, pressures and criticisms that pharmacy faces today, there are many reasons why the general practice of pharmacy (to ambulatory patients, in acute care hospitals and extended care facilities) will continue an ongoing evolution. The general practice of pharmacy will become increasingly recognized not only for its drug distribution and control responsibilities, but for informational services associated with the drug-therapy component that help optimize safe and effective use of drugs. The informational services include patient education regarding prescription and OTC drugs, drug therapy monitoring, drug information services to other health professionals and drug utilization activities. These are terms or concepts we have heard about, may be giving lip service to, may be involved in to some extent already with varying degrees of consistency and effectiveness. In my estimation, they will become recognized as integral parts of the general practice of pharmacy.

There is growing evidence that pharmacy education, through revision and refinements in its educational programs, is doing a better job of preparing graduates to help evolve these types of pharmacy services. Pharmacy practice likewise is beginning to understand the real needs of patients and other health professionals, not only for drug products but for information about those products. Consequently, pharmacy practice is involved in revising and refining its services to do a better job of meeting these perceived needs. Education and practice components are beginning to recognize the benefit we can be to each other in meeting our respective responsibilities. We are working together, learning from each other and being open to new ideas. We are also recognizing that both education and practice in isolation from other health professionals are inadequate in terms of educating pharmacy students to work with other health professionals in providing these kinds of patient services. This has been an important impetus for development of clerkship and externship programs.

Unlike the situation just five short years ago, federal health planners and legislators see the underutilized potential of pharmacy as being able to contribute more in the area of monitoring safe and effective use of drugs. And this perception has potential as drugs are increasingly becoming recognized as important components of cost-effective health care services. Drugs used inappropriately are seen as dollars spent unnecessarily on increased hospital and medical care costs because of the health consequences of overuse and underuse of drugs and of drug-induced disease. An information dissemination, acquisition and evaluation component of pharmacy service is becoming recognized as a uniquely valuable resource, *if* coordinated with services of other health professionals to enhance patient care and health maintenance.

In this regard, I am referring to organization of health care services by a variety of health care providers to improve the effectiveness, consistency and efficiency of patient care. Furthermore, I am talking about a philosophy of health care which actively involves the patient in his own health maintenance and disease control. This, of course, will not just happen universally or instantaneously by government decree, by professional association resolution, or by wishful thinking. It will evolve over a number of years. This evolution is already underway but requires better coordination of effort within and between the health professions. Furthermore, added impetus from third-party payers who want to encourage this evolution for cost containment and quality assurance reasons, will surely enhance the rate of this evolution.

The components of our present health care structure are so great in number and complex in their present organization (or disorganization), it isn't likely that a single form of organization or institutionalization of health services will evolve or will be decreed. Although hospitals will continue to be an important center for inpatient and outpatient health care services, extended care facilities, clinics, neighborhood community pharmacies will also continue to be involved to the extent that these units truly become involved in a type of organization of effort which coordinates services with other health care providers to individual patients.

For ambulatory patients, for example:

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b. patient education on proper use of the drug will become a regular feature of pharmacy services, but coordinated with the educational input from physicians, nurses or nurse practitioners, public health nurses or social workers, etc.;

c. drug therapy monitoring for proper use and appropriate response will become a regular feature of the pharmacist's review of patient medication utilization and the acquired information will be fed into the system for use in making future therapy decisions;

d. patient advising on self-medication and referral to other health professionals when appropriate will also become increasingly recognized as a component of community pharmacy services.

Similarly, drug distribution and drug information services in extended care facilities, acute care hospitals and mental health facilities will involve pharmacy, medicine and nursing, working together to coordinate their services for improved health care from both a quality and cost basis.

Today's Education Answering Tomorrow's Needs

Although oversimplified in my presentation, this view of the types of pharmacy services which will be evolving over the next ten years, do help us identify the types of information needs of patients and other health professionals, the types of pharmacy service systems that will provide drug distribution and informational services and the nature of relationships between pharmacists and other health care professionals necessary to optimizing information flow. This perspective on the *needs of pharmacy practice* for future developments contributes to a determination of the *types of competencies* or abilities which pharmacy graduates of today will need. The education and training of pharmacy students should be appropriate to meet the pharmacy practice needs of today as well as to meet the foreseeable evolving needs in the next several years.

Both judgmental and non-judgmental features will be involved in each of the many components of pharmacy services. To achieve the objectives of efficiency, consistency, accuracy and optimal use of professional personnel in the judgmental components of service, management skills will need to be applied to determine the appropriate use of computers, mechanization and supportive personnel to complement the work of the pharmacist. So what types of pharmacy supportive personnel should we be training to meet these *future* needs? I don't know nor do I feel we need to worry about that now because, although pharmacy student education should be geared to develop graduates with competencies for *present* and *future* needs, in my view technician training at any given point in time should be appropriate to prepare for that day's needs and that day's needs only.

Although I am willing to discuss with some confidence the type of pharmacy services that will be likely evolving in the next ten years and thus the kinds of abilities that our schools should be preparing pharmacy graduates to have, I am much less confident about the functions of supportive personnel in ten years. This is because pharmacy aids or supportive personnel represent only one type of supportive aid which pharmacists will be utilizing to help with the technical, nonjudgmental aspects of providing pharmacy services. These include mechanization (counting machines, automatic typewriters), computers and other technological advances not yet being utilized in pharmacy. All of this technology will continually alter the types of manipulative, nonjudgmental activities which technically trained people will need to do.

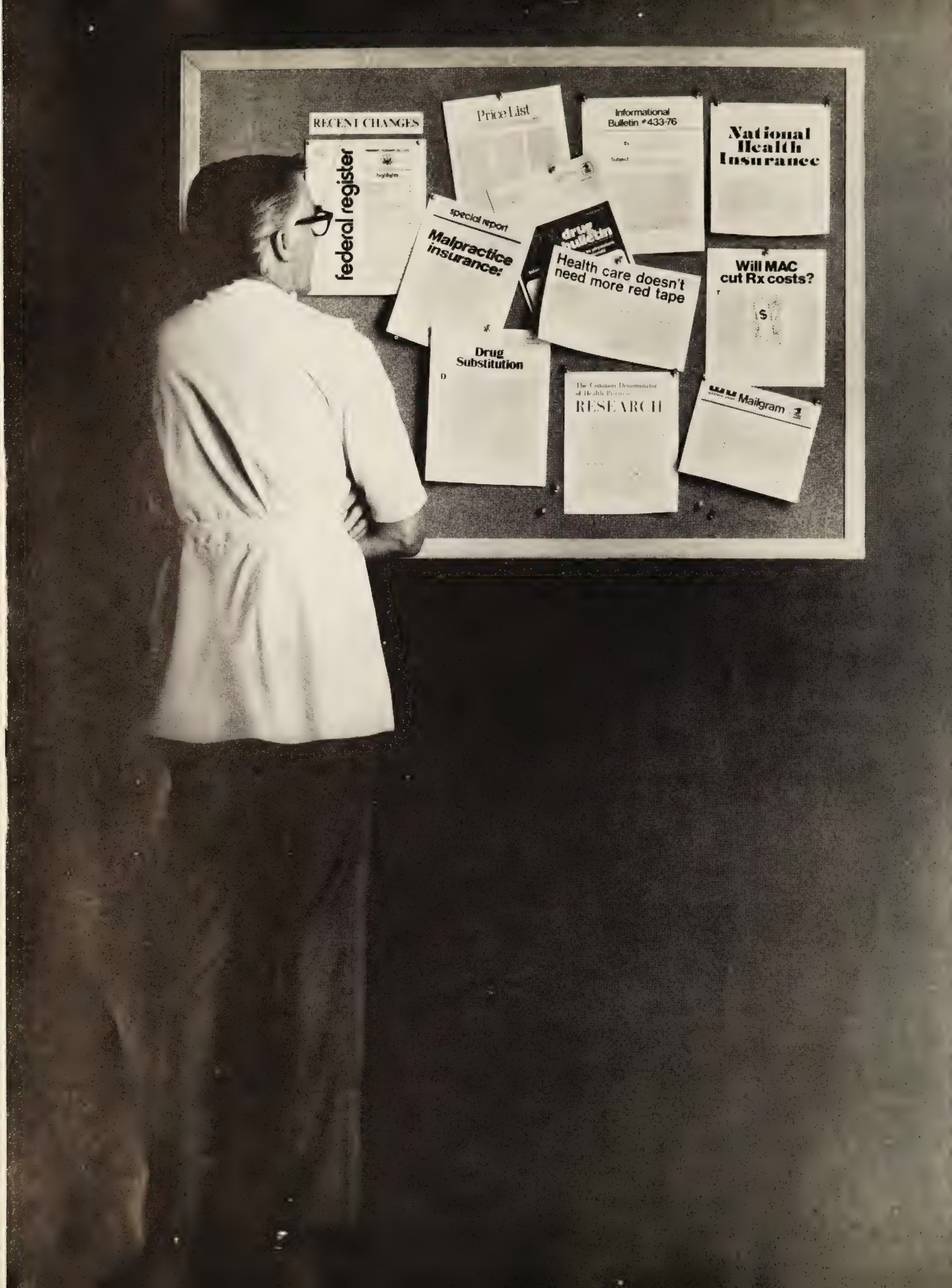
Freeing the Pharmacist

Thus with respect to training and utilization of supportive personnel, it would seem our most productive avenue for discussion would be consideration of how we can begin or continue to improve the efficiencies of our practices *today* to free up the pharmacist for increased involvement in the information aspects of services without decreasing the safety of the drug distribution aspects of services. (a) This would include the use of computer services and mechanization to an increasing extent. (b) This would include use of supportive personnel in a variety of ways but for most effective utilization there should be *proper supervision, adequate training* to optimize their contribution to the pharmacy's stated goals and *appropriate motivational management* input to optimize their job satisfaction.

Two years ago in 1974, I was chairman of the Professional Affairs Committee within the American Association of Colleges of Pharmacy and our charge was to "accumulate the kind of information on pharmacy supportive personnel which would aid the Association in establishing a position: (a) On the need for and functions of these supportive personnel, (b) On who whould be responsible for the educational programs to prepare these individuals and (c) On what the training program should contain." The literature reviewed by the Committee involved reports of supportive personnel training and utilization programs, position statements of national and state associations of boards of pharmacy, and a cross section of analyses and commentaries on the subject of supportive personnel. Stated positions of professional associations and regulatory agencies represented a spectrum of positive and negative viewpoints on the use and training of supportive personnel.

In 1974 (and today as well) supportive personnel use in pharmacy represents a spectrum, from involvement with appropriate technical functions with proper pharmacist supervision to involvement with functions which exceed supportive personnel education; and training programs are emerging, in some cases pharmacist-generated programs that appear to be appropriate to specific jobs and functions that are known to exist; in some cases pharmacist-generated programs that appear to be haphazard in their preparation of persons for specific jobs and functions; and in some cases education/graining programs arising as an activity of technical schools or junior colleges that appear to have little pharmacy input as to the need for or nature of the program.

(Continued on page 30)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Pharmacy today is in the spotlight, subjected to all kinds of scrutiny. Your actions are being monitored and judged, sometimes by unknown third parties.

The worry is that in the wake of this focus, your relationships with both doctors and patients will be weakened, without offsetting benefits. Consider three examples:

Drug substitution Until recently, state pharmacy laws, regulations, or professional custom have stipulated that non-generic prescriptions be filled with the precise products prescribed. But in the last five years, a number of these laws or regulations have been changed, permitting you, in varying degrees, to make the selection when a multi-source product is ordered.

These changes have been taking place against a background of growing evidence that purportedly-equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA has not enforced the same standards for hundreds of "follow-on" products that it has applied to original NDA approvals. This situation, it seems to us, is a compelling reason for product selection to rest on a sensible interchange between doctors and pharmacists—and not on legislative action.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant overall savings has been produced, nor is any likely, given the needs of pharmacy and the record of government in administering cost control programs.

MAC Maximum Allowable Cost, MAC for short, is a federal regulation intended to cut the government's drug bill by setting price ceilings for multi-source drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right, regardless of your economic or professional judgments. Pharmacists will have little to say about administration of the program, since government will have absolute authority to make its prices and fees stick. For other multi-source drugs on the MAC list, your reimbursement would be limited to a product price on a government "estimated acquisition cost" list and a state-established professional fee.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to patients: the cost of the research is more than ten times what it was, per product, in 1962, and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years or more now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present complex approval process contributes to needless delay of drug therapy. That's why the increased efficiency of the drug and device approval process is vital to all our futures.

We suggest you make your voice heard on these issues —among your colleagues and your representatives in state legislatures and in the U.S. Congress.

It could make a difference to patients and to the practice of your profession tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
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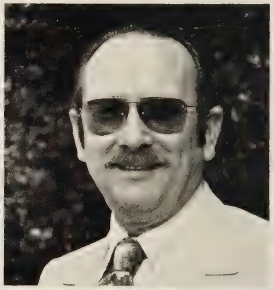
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Regulatory Agencies and the Pharmacist

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Get the facts at the MPhA

Annual Swain Pharmacy Seminar

Co-sponsored by the University of Maryland School of Pharmacy

THURSDAY, March 17, 1977

Quality Inn — Towson
1015 York Road — Beltway Exit No. 26S

8:30 A.M. Registration Opens — Coffee and Danish

9:00 A.M. "Drug Control Responsibilities"
Panelists: Federal DEA (Drug Enforcement Agency) — *RONALD W. BUZZEO*, Chief, Compliance Division
Maryland State Department of Health, Division of Drug Control — *CHARLES H. TREGOE*, Chief
Maryland Board of Pharmacy — *I. EARL KERPELMAN*, President
Moderator: *PHILIP H. COGAN*, Seminar Chairman

11:15 A.M. "Pharmacists' Responsibilities under the U.S. Consumer Product Safety Commission" — Safety closures and new container requirements.
— *GEORGE MAISEL*, Director of the Division of Poison Prevention Packaging

12:00 LUNCHEON
Speaker: *ROBERT G. PINCO*, Director, OTC Drug Evaluation Division, FDA. "The OTC Review Program — Implications for Pharmacists"

1:45 P.M. After Lunch Session — "The Pharmacist's Role in Supplying OTC Drugs"
"Providing OTC Information to the Public — Legal Aspects" Ramifications of permitting clerks to give medication information.
JOSEPH S. KAUFMAN, MPhA Legal Counsel and former Deputy Attorney General, State of Maryland.

Quick Decisions and Responses

The pharmacist's emerging role as an adviser to the public on OTC's — their selection, proper use and contraindications in relation to other drugs, both prescription and non-prescription — involves new professional and legal responsibilities. The following portion of the Swain Seminar program uses two widely used classes of drugs — laxatives and anti-diarrheals — to illustrate the kind of knowledge pharmacists require in order to make quick decisions and responses to patrons' questions in pharmacies.

PANEL:

"Non-Prescription Drugs" A Case Study, Laxatives and Anti-Diarrheals"
Moderator: *RALPH F. SHANGRAW*, PhD., Department Chairman and Professor, Department of Pharmacy, University of Maryland School of Pharmacy.

"Anatomy and Physiology of the Gastro-Intestinal Tract"
J. EDWARD MORETON, PhD., Assistant Professor, Department of Pharmacology and Toxicology, University of Maryland School of Pharmacy

"Drug Products and the OTC Review"
MR. ROBERT G. PINCO, FDA

"Patient Assessment and Management"
JOHN M. HOOPES, Pharm. D., Assistant Professor, Division of Clinical Pharmacy, Clinical Pharmacist, Family Health Center, University of Maryland.

PANEL REVIEW: Questions and Answers

Registration fee includes luncheon, coffee service and seminar materials kit.

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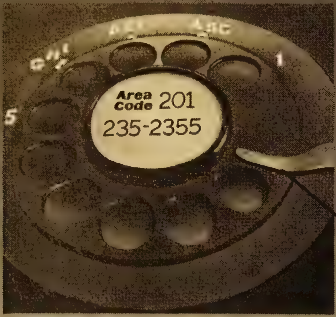
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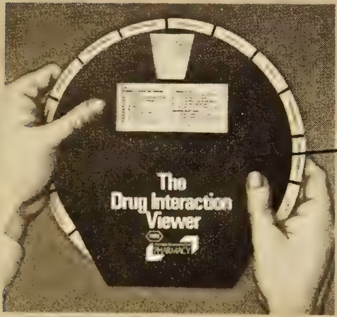
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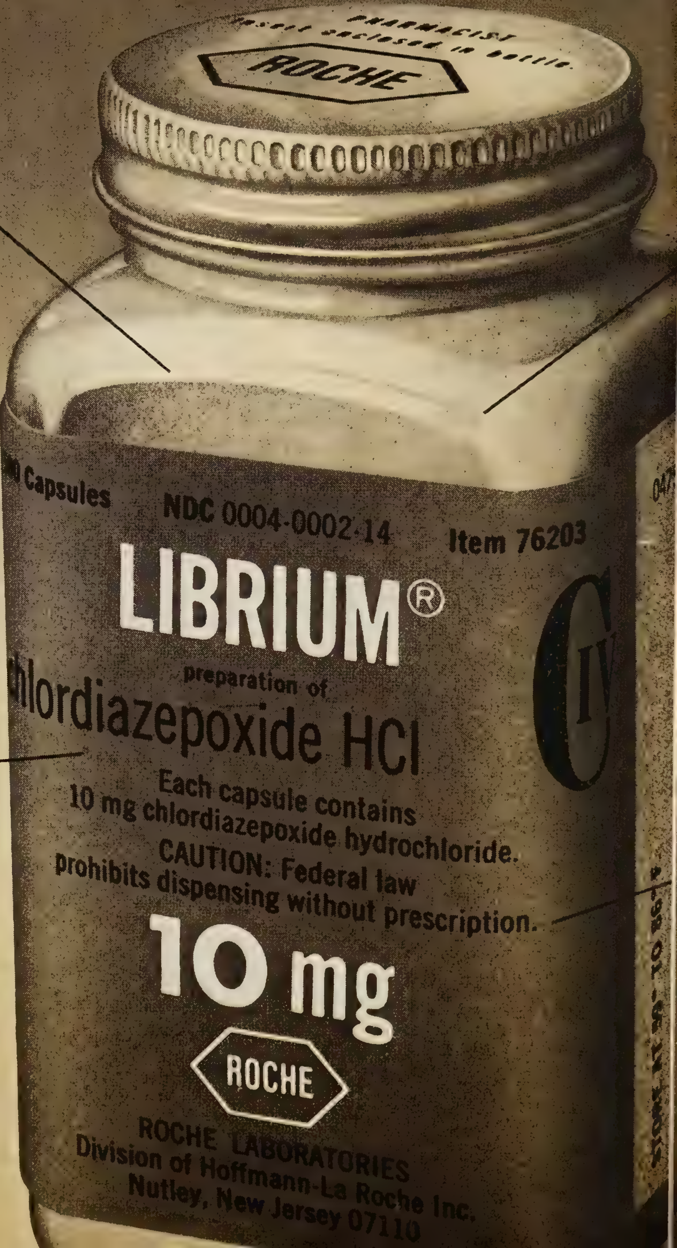
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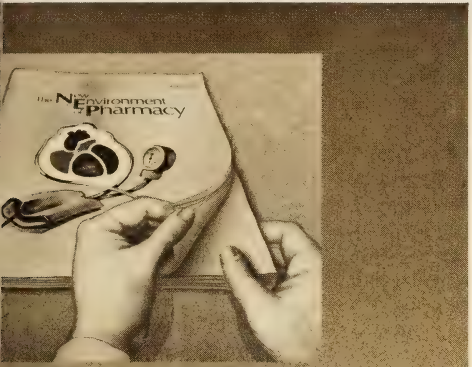

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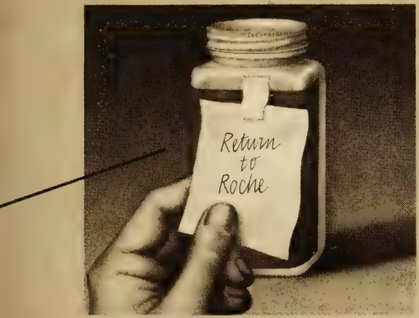

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Roche Laboratories will reimburse pharmacists for all Roche products which may be outdated or discontinued. This makes it possible to keep your stock of Roche products always up to date and helps you maintain an active, profitable inventory.

Please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Beclomethasone Dipropionate

by Thomas C. Majerus, Pharm.D.*

Manufacturer Recommended Indications

Beclomethasone dipropionate (Vanceril®) is indicated only for patients who require chronic treatment with corticosteroids for control of the symptoms of bronchial asthma. Such patients would include those already receiving systemic corticosteroids, and selected patients who are inadequately controlled on a nonsteroid regimen and in whom steroid therapy has been withheld because of concern over potential adverse effects.

The drug is not indicated for relief of asthma which can be controlled by bronchodilators and other nonsteroid medications; in patients who require systemic corticosteroid treatment infrequently; or in non-asthmatic bronchitis.

Administration and Dosage (Manufacturer's)

Adults: Usual dosage is 2 inhalations (100 mcg) given 3 or 4 times a day. In patients with severe asthma, start with 12 to 16 inhalations a day and adjust dosage downward according to response. Do not exceed 20 inhalations daily.

Children: (6 to 12 years of age): Usual dose is 1 or 2 inhalations 3 or 4 times a day according to response. Do not exceed 10 inhalations. Insufficient clinical data exists with respect to administration in children under 6.

Patients receiving bronchodilators by inhalation should be advised to use the bronchodilator before beclomethasone aerosol in order to enhance penetration of beclomethasone into bronchial tree. After use of an aerosol bronchodilator, several minutes should elapse before use of beclomethasone aerosol to reduce the potential toxicity from the inhaled fluorocarbon propellants.

Evaluation

In clinical studies[8] it has been shown that there is a clear separation between the inhaled dose of beclomethasone dipropionate required to control bronchial asthma (400 mcg per day) and that needed to reduce 9 A.M. plasma cortisol levels (2 to 3 mg per day). Other studies[15] have indicated that when standard doses (400 mcg per day) do not control symptoms, the dose could be increased and the benefits increased proportionately more than adrenal suppression. In patients who were given beclomethasone dipropionate instead of their usual systemic steroids[12], almost complete recovery of adrenal function occurred within six months and without effect on Hypothalamic-Pituitary-Adrenal axis in patients previously receiving no systemic steroids. In children[7] who were weaned off systemic steroids or corticotrophin, their adrenal function was normal as measured by morning plasma cortisol levels. There were no side effects, apart from the reappearance of hayfever or eczema in some children previously on systemic steroids.

Control of asthma has been good and this has been particularly true in children although as has been mentioned, concurrent hayfever or eczema was unmasked when systemic corticosteroid therapy was withdrawn[17]. No influence on blood sugar metabolism or growth hormone production could be demonstrated after six months use of beclomethasone dipropionate aerosol[17]. In another study[10], 70% of patients previously taking oral corticosteroids were able to discontinue such treatment under close supervision. It is important to remember that ventilatory function tests improve slowly and sometimes take several months to achieve the maximum benefit[17]. Other studies have compared 400 mcg with 800 mcg per day doses of beclomethasone dipropionate with placebo in steroid-dependent asthmatics[2]. Here 400 mcg per day was effective therapeutically and permitted a 50% decrease in oral prednisone in 62% of the patients taking 15 mg or less per day. In patients taking 16 mg or more, 800 mcg per day was more effective. Another study[1] has concluded that addition of beclomethasone dipropionate to systemic corticosteroid therapy allows a useful decrease to be made in the oral maintenance doses of corticosteroids. However, this reduction must be made with caution since there is wide individual variation in response to beclomethasone dipropionate and in only a minority of patients can oral treatment be completely withdrawn[1]. An additional conclusion was reached; the use of inhaled beclomethasone dipropionate gives better therapeutic effect and less systemic steroid effects than oral prednisolone[4].

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*Dr. Majerus is an Instructor in Clinical Pharmacy, University of Maryland School of Pharmacy.

There have been varying reports concerning candida infections in users of beclomethasone dipropionate. Some have found a slight increase in frequency of thrush that in each case was caused by candida[13]. Others have declared that beclomethasone dipropionate appears to be free from important side effects even in doses up to 800 mcg per day and monilial infections were not found significantly more often in aerosol-treated children compared with control asthmatics[5,14,9]). Still others have shown a high incidence of oropharyngeal candidiasis[2]. Incidence was 77% of those on 800 mcg per day and 45% of those on 400 mcg per day and 9% who were on placebo. However, none had to discontinue the beclomethasone inhaler due to candidiasis and none developed bronchopulmonary candidiasis[2]. Since corticosteroids can cause skin atrophy with prolonged topical administration, the possibility that local atrophic changes might also occur in the respiratory tract with long-term use cannot be ignored. So far, on bronchial mucosa biopsy, no signs of atrophy, epithelial metaphlasia or membrane thickening could be recognized[13]. It seems safe to say that the higher the dose, the greater the frequency of oro-pharyngeal candidiasis. The higher doses should be reserved for patients not responding to lower doses and for patients with severe asthma that require the use of 16 mg of prednisone or more[3].

While there has been good control without adrenal suppression or growth suppression and without important side effects[16], it will still be necessary to use occasional short courses of supplemental oral steroids at times of exacerbation not brought under control by increase in beclomethasone aerosol[6]. Four hundred mcg per day is the recommended dosage regimen and should be used when possible, but if systemic steroid side effects exceed the risk of colonization with candida albicans, the 800 mcg per day dosage is worthy of a trial[2].

When compared with dexamethasone inhaler and when each was given 1 mg I.V., only dexamethasone caused adrenal suppression. The absorption from the gastrointestinal tract of the swallowed portion of the inhaled dose of dexamethasone is the cause of its systemic glucocorticoid activity. The lack of activity of swallowed beclomethasone dipropionate aerosol is most likely due to the absorbed steroid being converted during its passage through the liver to pharmacologically inactive metabolites[11].

Beclomethasone dipropionate (Vanceril) is supplied as a metered dose inhaler of 10 mg per inhaler which delivers 200 doses of 50 mcg each.

Dexamethasone sodium phosphate (Decadron Respihaler) is supplied as an aerosol of 12.6 grams per aerosol which delivers 84 mcg per dose.

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Drug Information Center Opens at University Hospital

The Department of Pharmacy Services of the University of Maryland Hospital has reopened its Drug Information Center, now located in the 11th floor Patient Care Pharmacy at University Hospital. The new center is under the direction of Jack Krause R.Ph. The center will provide drug related informational services to all health professionals within the University complex, and will hopefully stimulate interdisciplinary discussion about drugs.

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 09 Medical Care Programs

Chapter 03 Pharmacy Services

Authority: Article 43, §§1F(d), 42; Article 41, §206

.01 Definitions.

A. "Allowable Cost" means the manufacturer's or wholesaler's invoice price for procuring the product, not to exceed an upper limit established by the Department.

B. "Approved Unit Dose System" means a drug distribution system approved by the Department that is used to prepare and distribute an individual, properly labeled dose of medication for a patient in a nursing facility.

C. "Convenience Package" means a smaller quantity or specially packaged quantity of a product prepared for convenience of patient or pharmacist as opposed to regular packages.

D. "Department" means the State Department of Health and Mental Hygiene, the single state agency designated to administer the Medical Assistance Program under Title XIX, Social Security Act, 42 U.S.C. § 1396 et seq.

E. "Drugs" means legend drugs (those requiring a prescription under Federal or State law) or over-the-counter (OTC) drugs (those not requiring a prescription under Federal or State law).

F. "Formulary" means a list of generic drugs published by the Department according to Article 43, § 42, Annotated Code of Maryland.

G. "Free Standing Clinics" means those clinics, not associated with a hospital, which are under the direction of physicians.

H. "Institutional Pharmacy" means a pharmacy owned and operated by a hospital, nursing facility, or clinic.

I. "Invoice" means a pharmacy invoice (a form issued or approved by the Department for use by providers in submitting bills for payment) or a manufacturer or wholesaler invoice (a bill issued by a manufacturer or wholesaler to the provider which indicates proof of purchase and the price paid by the provider).

J. "Maximum Allowable Cost" (MAC) means a price limitation established by the Pharmaceutical Reimbursement Board of the Department of Health, Education and Welfare.

K. "Medical Assistance Program" means a program of comprehensive medical and other health-related care for indigent and medically indigent persons.

L. "Nursing Facility" means an establishment authorized to participate in the Program, and classified as either a skilled nursing facility or an intermediate care facility.

M. "Pharmacist" means an individual licensed to practice pharmacy in the state where the prescription is filled.

N. "Pharmacy" means an establishment or institution legally authorized to dispense legend drugs to the public in the state in which the establishment or institution is located.

O. "Preauthorization" means an approval required from the Department or its designee before the dispensing of the prescription.

P. "Prescriber" means a physician, dentist, podiatrist, or other professional licensed to prescribe legend drugs and authorized by the Department to participate in the Program.

Q. "Prescription" means a written order for medication, medical supplies or equipment signed by the prescriber.

R. "Program" means the Maryland Medical Assistant Program.

S. "Provider" means a pharmacy recognized by the Department to participate in the Program.

T. "Recipient" means a person who is certified as eligible for, and is receiving, Medical Assistance benefits.

.02 License Requirements

A pharmacy may not qualify as a provider without first having obtained a permit from the Department pursuant to Article 43, § 249 et seq., Annotated Code of Maryland, or from the appropriate agency in the state in which the pharmacy is located.

.03 Provider Qualifications and Conditions for Participation.

To participate in the Program, the provider shall:

A. Meet the license requirements in Regulation .02 above;

B. Apply for participation in the Program using the application form designated by the Department;

C. Be approved for participation by the Department;

D. Accept payment by the Program as payment in full for the professional services rendered and make no additional charges to the patient or the patient's family except as provided in Regulation .05 B(5) below;

E. Maintain adequate records (the provider shall maintain prescriptions for a minimum of 5 years and make them available for inspection, upon request, to the Department or its designee);

F. Include on all prescriptions sufficient information to justify the pharmacy invoice charges;

G. Provide services without regard to race, creed, color, age, sex, national origin, marital status, physical or mental handicap;

H. Not employ knowingly a person who has been disqualified from the Program to compound or dispense Medical Assistance prescriptions, unless prior written approval has been received from the Department;

I. Verify the recipient's eligibility;

J. Place no restriction on recipient's right to select providers of his choice.

.04 Covered Services.

Prescriptions for the following are covered when ordered and signed by prescribers for recipients within the limits established by the Program:

A. Legend drugs;

B. Insulin when prescribed in original packages;

C. Permanent urinary incontinent supplies excluding incontinent pads and rubber sheets;

D. Contraceptives other than condoms;

E. Needles and syringes;

F. Medical supplies with a retail cost less than $10, except as limited in Regulation .05 below.

.05 Limitations

A. The following are not covered:

(1) Non-legend drugs other than insulin;

(2) Medical supplies and durable equipment with a retail cost exceeding $10 (supplies costing more than $10 are covered under COMAR 10.09.12);

(3) Any original prescription dispensed more than 10 days after the prescribing date;

(4) Drugs supplied to hospital inpatients; drugs for hospital inpatients are covered under COMAR 10.09.06;

(5) Drug samples;

(6) Experimental or investigational drugs;

(7) Injectables dispensed by the pharmacist for administration by the prescriber (drugs administered by the prescriber are covered under COMAR 10.09.02, except where authorized by the Department to be covered under the Pharmacy Program);

(8) Food supplements, special diets, or infant formulas;

(9) Condoms for birth control;

(10) Sugar or salt substitutes;

(11) Cosmetics, medicine chest supplies, and sundries including all soaps, all body powders, all body oils or body lotions, cotton balls, adhesive strip bandages, cotton-tipped applicators, suntan products, deodorants, dentifrices, tissues, convenience packages of covered items, hot water bottles, ice caps, heating pads, soft cervical collars;

(12) Alcoholic beverages;

(13) Ostomy supplies (ostomy supplies are covered under COMAR 10.09.12);

(14) Those services authorized for payment to a prescriber, hospital, nursing facility, hospital outpatient department, or free standing clinic.

B. Limitations on covered services.

(1) The allowable cost of ingredients dispensed pursuant to a prescription may not exceed an upper limit as established in Regulation .07 below.

(2) Refills.

(1) The prescriber shall authorize refills on the original prescription;

(b) The Program will authorize no more than two refills;

(c) Only the original provider may dispense refills.

(3) The total treatment time covered by an original prescription and its refills may not exceed 100 days except for birth control pills which are limited to a 6-cycle supply.

(4) When the drug product is prescribed by its non-proprietary or generic name, the provider shall dispense the least expensive product of equal therapeutic effectiveness available.

(5) There will be a 50-cent co-payment by the recipient for each covered service.

.06 Preauthorization Requirements.

The pharmacist shall obtain preauthorization from the Department or its designee for any prescription with an ingredient cost exceeding $20. Drugs dispensed to patients in a nursing facility by a pharmacy using an approved unit dose system are exempt from this requirement.

.07 Payment Procedures.

A. The provider shall produce records to verify any charge to the Program upon request.

B. The provider shall bill all appropriate insurance carriers before requesting payment from the Department.

C. The Department will not reimburse for invoices submitted for payment more than 9 months after the date of service.

D. The provider shall submit a request for payment on a form designated by the Department.

E. The Department may return to the provider all invoices not properly completed.

F. The provider shall charge the Program his usual and customary charge to the general public for similar prescriptions.

G. Determination of Allowable Cost.

(1) For multiple source drugs designated by the Pharmaceutical Reimbursement Board of the Department of Health, Education, and Welfare or for each formulary drug, allowable cost shall be the lowest of:

(a) Maximum Allowable Cost;

(b) The upper limit established by the Department based on the lowest price at which the drug is generally available throughout the State;

(c) The estimated acquisition cost as defined in §G(2), below. When a prescriber certifies in his own handwriting that, in his judgement, a specific brand is medically necessary, the estimated acquisition cost as defined in §G(2), below, shall be the allowable cost instead of §G(1)(a) or (b), above.

(2) For all other prescribed drugs, the allowable cost shall be the estimated acquisition cost established by the Department. This cost is an estimate of the price generally paid by providers for a drug and is based upon package size, availability, and prices submitted to the State by the Department of Health, Education, and Welfare.

H. Payment for Covered Services. The Department will pay for covered services as follows:

(1) Payment for legend drugs shall be the lower of:

(a) The provider's charge according to §F above, less co-payment; or

(b) The allowable cost of the item in §G, above, plus a $2 professional fee, less co-payment;

(2) Payment for over-the-counter drugs shall be the lowest of:

(a) The provider's charge according to §F, above, less co-payment; or

(b) The allowable cost plus 50 percent, less co-payment; or

(c) The allowable cost plus $2 professional fee, less co-payment.

(3) Payment for medical supplies and durable equipment shall be the lower of:

(a) The provider's charge according to §F, above; or

(b) The upper limit established by the Department based upon the lowest price at which the product is generally available throughout the State.

(4) The Department may pay providers using an approved unit dose system on the basis of a daily or monthly dispensing fee per resident. The value of these fees may not be higher than the pharmacist's usual and customary charge to non-Medicaid patients for similar services.

I. In order to determine whether the current professional fee is appropriate, the Department will periodically conduct surveys to determine the actual costs involved in filling a prescription in the State.

.08 Recovery and Reimbursement.

A. If the recipient has insurance or other third-party coverage, the provider shall seek payment from that source. If payment is made by both the Program and the insurance or other third-party source, the provider shall refund to the Department, within 60 days of receipt, the amount paid by the Program, or the insurance or third-party source, whichever is less.

B. The provider shall reimburse the Department for any overpayment.

.09 Cause for Suspension or Removal and Imposition of Sanctions.

A. If the Department determines that a pharmacy or pharmacist, or both, has failed to comply with the applicable Federal and State laws and regulations, the Department may initiate one or all of the following:

(1) Suspension from Program;
(2) Withholding of payment by the Program;
(3) Removal from the Program.

B. If the Secretary, Department of Health, Education, and Welfare, suspends or removes a pharmacist or pharmacy, or both, from participating in Medicare (Title XVIII, Social Security Act, 42 U.S.C. § 1395 et. seq.), the Program may take similar action.

C. The Department may consult with the State Pharmaceutical Association and the State Board of Pharmacy. The findings and recommendations of these groups will be given consideration.

D. The Department will give the provider reasonable notice of its intentions to impose sanctions. In the written notice, the Department will establish the effective date and the reasons for the proposed action, and advise the provider of the right to appeal.

E. Any provider voluntarily withdrawing from the Program or removed or suspended from the Program according to this section shall notify recipients that he no longer honors Medical Assistance cards before rendering additional services.

.10 Appeal Procedures.

Providers filing appeals from administrative decisions made in connection with these regulations shall do so according to Article 41, §§206A and 206B, and Article 41, §244 et seq., Annotated Code of Maryland.

Effective date: September 1, 1976 (3:18 Md. R. 981)

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Nathan I. Gruz, Editor
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Maryland Medical Assistance Pharmacy Guideline No. 1

Revised Pharmacy Regulations 10.09.03 became effective September 1, 1976. Copies of the Regulations were mailed to all providers when they became available. All guidelines or policies in conflict with the existing Regulations are superseded. Listed below are some of the key sections or changes in the Regulations:

A. An upper price limitation has been established for each covered drug product. This upper limitation will be known as the Estimated Acquisition Cost (EAC) for single source drugs or the Maximum Allowable Cost (MAC) for multiple source drugs on the State Formulary or drugs covered by Federal MAC Regulations.

B. Maryland Medical Assistance Program covers the cost of legend drugs. Legend drugs are defined as those drugs which require a prescription BY FEDERAL OR STATE LAW. The Program *does not* cover the cost of drugs which are legend items by virtue of local statute or ordinances.

C. Prescriptions for the following are covered when ordered and signed by prescribers within Program limitations:
   1. Legend drugs;
   2. Insulin when prescribed in original packages;
   3. Permanent urinary incontinent supplies excluding incontinent pads and rubber sheets;
   4. Contraceptives other than condoms;
   5. Needles and syringes; and
   6. Covered medical supplies with a retail cost of less than $10.

D. The following are not covered:
   1. Non-legend drugs other than insulin;
   2. Medical supplies and durable equipment with a retail cost exceeding $10 (supplies costing more than $10 are covered under COMAR 10.09.12-Medical Supply Regulations);
   3. Any original prescription dispensed more than 10 days after the prescribing date;
   4. Drug samples;
   5. Experimental or investigational drugs;
   6. Injectable drugs dispensed by the pharmacist for administration by the prescriber except where authorized;
   7. Food supplements, special diets, or infant formulas;
   8. Condoms for birth control;
   9. Sugar or salt substitutes;
   10. Cosmetics, medicine chest supplies, and sundries including all soaps, all body powders, all body oils or body lotions, cotton balls, adhesive strip bandages, cotton-tipped applicators, suntan products, deodorants, dentifrices, tissues, convenience packages of covered items, hot water bottles, ice caps, heating pads, soft cervical collars;
   11. Drugs supplied to hospital inpatients, which are covered under COMAR 10.09.06; and
   12. Ostomy supplies (covered under COMAR 10.09.12).

E. The total treatment time covered by an original prescription and its refills may not exceed 100 days, except for birth control pills which are limited to a 6-cycle supply.

F. When the drug product is prescribed by its generic name, the pharmacy *must* dispense the least expensive product available in the pharmacy.

G. Pharmacists are reminded that effective September 1, 1976, the DHMH-235 and DHMH-236 invoice forms must contain only the pharmacy's usual and customary charge. This charge may not exceed the charge to the general public for the same product and quantity.

H. Pharmacies servicing nursing homes with an approved unit dose system must submit bills for these services on the DHMH-235M (Multiple Prescription Form). The DHMH-235M must contain the cost plus a fee, as in the past.

I. Over-the-Counter products (insulin) will be reimbursed *at the lowest of:*
   1. Usual and customary (less $. 50 co-pay);
   2. Allowable cost plus 50% (less $. 50 co-pay), or
   3. *Allowable cost plus $2 (less $. 50 co-pay).*

J. The State will conduct periodic surveys to determine the pharmacy cost associated with filling prescriptions.

K. If a provider fails to comply with federal and state regulations, the pharmacy may:
   1. Have payment withheld by the Department,
   2. Be suspended by the Program, or
   3. Be declared ineligible and be permanently removed from the Program.

L. Any provider voluntarily withdrawing from the Program or removed or suspended from the Program according to these regulations shall notify recipients that he no longer honors Medical Assistance cards before rendering additional services.

M. The Pharmacist shall obtain preauthorization from the Local Health Department for all prescriptions with an ingredient cost exceeding $20. It is recommended, to overcome computer problems, that preauthorization be obtained for all prescriptions with a usual and customary charge in excess of $20.

   Preauthorization is no longer required for prescriptions for antibiotics in excess of a 10 day supply unless the cost exceeds $20.

N. Drugs dispensed to patients in a nursing facility by a pharmacy using an approved unit dose system are exempt from the preauthorization requirement.

O. All prescriptions, except birth control pills, may be refilled up to 2 times within 100 days when authorized by the prescriber. Birth control pills may be refilled up to 2 times within 180 days. Antibiotics may also now be refilled similar to other products.

The total amount dispensed may not exceed a 100 day supply except for birth control pills which are limited to a 6 cycle supply.

The following telephone numbers are included for your information:

Questions concerning the drug prices in the computer and returned invoices	383-6893
Questions concerning possible payment errors	383-6481
Policy questions	383-2658

Pharmacy Bulletin Maryland Medical Assistance Program Number 14 — December 10, 1976

The Maryland Medical Assistance Program has encountered some problems since the implementation of the Automated Drug Pricing System on September 1, 1976. We have listed below recommendations which will benefit pharmacy providers and the Program.

1. **National Drug Code (NDC) Number**
   a. EVERY EFFORT MUST BE MADE TO INSURE THAT THE NDC NUMBER IS CLEAR AND LEGIBLE. ILLEGIBLE AND INCORRECT NDC NUMBER AND QUANTITY ACCOUNT FOR 80% OF THE PROBLEM INVOICES. MOST OF THESE ERRORS COULD BE ELIMINATED IF YOU WOULD REVIEW PRESCRIPTIONS FOR CLARITY.
   b. The numbers must be in the right-most position with zeros preceding the number. (Example — Manufacturer #40 should be 00040, Manufacturer #365 should be 00365, Manufacturer #2 should be 00002).
   c. NDC numbers with alpha characters are not acceptable. Only numeric digits are in the computer. Effective October 1, 1976, all drug manufacturers are using numeric drug codes which are listed in the Red Book or the Blue Book.
   d. Pharmacists are incorrectly using the 999-000 "dummy number". This number should be used *only* when the NDC is not on the container, listed in the Red Book, Blue Book, or Manufacturer's Catalog. All invoices containing "dummy numbers" will be suspended for manual handling, which will increase processing time and may delay payment.
   e. Please continue to indicate the brand dispensed on generic prescriptions. This request is made at this time because there is no current numeric list of Manufacturer codes. Inclusion of the name of the company will expedite your payment.
   f. The following NDC numbers are to be used when appropriate:

Needles and Syringes (under $10)	-00996-1111-00
Catheters (under $10)	-00996-2222-00
Any other Medical Supply Payable through the Pharmacy Program (under $10)	-00996-0000-00

Covered Medical Supplies or Durable Equipment with a Retail Cost over $10 must be billed to the MediCAID Medical Supply or MediCARE Programs.

Compounded prescriptions	-00998-0000-00
Legend Drugs without NDC	-00999-0000-00

NOTE that the previously issued number of *997-0000-00* for OTC drugs is *not valid* at this time.

2. **Quantity of Medication**
   a. Do not include the units of measure in the quantity blocks. Include only the numeric quantity. Do not write ml, cc, tabs, gm, etc.
   b. Enter whole numbers only. Do not enter fractions (⅜) or decimals (3.5). If the quantity dispensed is a decimal, raise the decimal to the next highest whole number. Example: *3.5 Gm* tube of ophthalmic ointment *should be sent in as 4.*
   c. The quantity dispensed should always be the number of tablets, capsules or suppositories dispensed; the ml (cc) of liquids dispensed and the Grams of ointments. NOTE: Always *indicate* the *number* of birth control pills *rather than compacts*, the *grams* of ointment *rather than tubes.*
   d. *Special package instructions, exceptions to 2 (c), above.*

	Indicate
K-lor	Number of packets
Alupent Inhaler	Number of milliliters
Chloromycetin Ophthalmic Drops	Number of bottles
Phospholine Iodide Ophthalmic Drops	Number of bottles

3. **Patient Identification** — Every effort must be made on each prescription to use the patient's plastic MediCAID card with the imprinter. Errors of transposing numbers frequently occur when the 11 digit number is handwritten. The name must also be clear since the name is keyed into the computer along with the patient's case number.

4. The duplication of plastic or metal cards in the format or type size of Maryland Medical Assistance cards for imprinting recipient information on our billing forms is prohibited.

Please do not hesitate to contact Mr. Joseph Fine, R.Ph., 383-6893, if you have any questions concerning this memorandum.

Degrees Conferred by Schools and Colleges of Pharmacy for the Academic Year 1975-1976

The office of Educational Research and Development has released the "Report on Degrees Conferred" for 1975-1976. Total degrees awarded by colleges of pharmacy reached an all-time high in academic year 1975-1976 of 8332, an increase of 1088 or 14.7 percent, with an additional 141 degrees awarded by the University of Puerto Rico. Of the total degrees in the continental United States, 6964 were baccalaureate degrees, representing an increase of 718 (11.5 percent) over the previous year. The percentage increase in number of baccalaureate degrees continues its downward trend; down from 13.7 percent increase in 1974-1975 and 14.0 percent increase in 1973-1974.

In academic year 1975-1976, females continued to increase in numbers and in proportion of degree recipients. A total of 2452 degrees were awarded to female pharmacy students in 1975-1976; this total represents an increase of 534 students, an overall increase of 27.8 percent from 1974-1975. Females now comprise 29.4 percent of degree recipients up from 27.0 percent in the previous year. Female Pharm.D. recipients, nationwide, dramatically increased to a total of 278, an increase of 129.8 percent over 1974-1975; the majority of the increase was due to the three California schools. The increase in female B.S. and B.Pharm. degree recipients was 22.1 percent.

Representation of minority students as degree recipients dropped by 33 students in 1975, a decrease of 5.2 percent. The decrease was primarily caused by a decrease in the numbers of Asian American graduates. Black students increased to 216 recipients, an increase of 17.4 percent over the previous year. While there were slightly more Black students receiving degrees, the percentage of degrees awarded to Blacks slipped to 2.6 percent of the total. The number of Black students receiving advanced degrees remained static; seven M.S.'s were awarded and no Ph.D.'s were awarded to Black students.

Pharm.D. degrees awarded totaled 778 in 1975-1976, an increase of 329. Pharm.D. degrees accounted for over 30 percent of the increase in total degrees. In 1975-1976 colleges of pharmacy awarded 73.3 percent more Pharm.D.'s than in 1974-1975. Of the total, 98.5 percent of this increase took place in District 8 schools.

The growth in output of graduate level degrees in U.S. colleges of pharmacy was higher than the growth in undergraduate degrees. Awards of Master of Science degrees represented the entire increase. Production of M.S. degrees rose by 54 over 1974-1975, representing an increase of 15.9 percent. The number of Ph.D. recipients continued its recent downward trend. In academic year 1974-1975, 189 Ph.D.'s were awarded, an increase of five over 1973-1974; production of Ph.D.'s declined to 179 in 1975-1976, a decline of 10. Copies of the report are available from AACP for $2.00.

Consumer Product Safety Commission Proposes Drug Product Selection Role for Pharmacists

Chairman S. John Byington of the U.S. Consumer Product Safety Commission stated recently that pharmacists should make the drug selection for the prescriptions they dispense.

"This is not only a logical solution to our growing shortage of physicians, but also it would assure our citizens of safer and more comprehensive drug care," Byington said. "Today's responsible pharmacist keeps himself fully informed on all aspects of drug therapy. He is aware of new discoveries. He is constantly informed of new risks or potential side effects. He is familiar with costs so that he can better advise patients.

"With so many people going to so many different physicians for different ailments — and with the potential for adverse drug reactions being so significant and serious, it is essential that there be a central pharmaceutical control and coordination over each patient's and family's drug therapy," Byington said.

Byington, a pharmacist and attorney, made his proposal in an address prepared for the dedication of a new pharmacy building at Auburn University. Byington said his opinions on the role of the pharmacist were expressed as a fellow pharmacist and not as a public official.

The independent regulatory agency which Byington heads administers the Poison Prevention Packaging Act. In his speech, Byington said that child-resistant packaging regulations under that Act had proved their worth. He said accidental deaths from poisoning among children under five had declined 38 percent after the aspirin standard became effective and that the number of deaths of children from aspirin poisoning had declined 48 percent.

Byington acknowledged that safety packaging was oftentimes inconvenient but that thanks to the consumer use of child-resistant packaging, it works to save lives.

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Pharmacists' Role in Dental Care

Members of the public can benefit from pharmacists' knowledge of good oral hygiene practice between visits to the dentist, according to an article by Harold Miller, D.D.S., M.P.H., of The New York University College of Dentistry.

"Preventing the onset of oral disease means practicing prevention at its primary level, the pre-pathologic period," he wrote in the winter issue of *Guidelines to Professional Pharmacy*.

"It is at this level that pharmacists can play a key role as health-team members. They see the potential patient in sickness and in health — those in acute pain, those in chronic pain, those 'a bit under the weather' and those feeling 'on top of the world.' "

The National Center for Health Statistics estimates that people pay about 295 million visits to dentists yearly in the U.S., averaging 1.5 visits per person.

Among people between 15 and 44, however, demand for dental care decreases sharply to about 0.5 visits per person per year. An estimated 98 percent of adults are afflicted with dental caries, while more than 90 percent of people over 45 suffer from "the silent invader," periodontal disease.

Almost 20 percent of the population has never visited a dentist, Dr. Miller wrote, and 40 percent go only in a crisis situation. Forty percent of all two-year-olds have dental caries — averaging two cavities per child. Oral cancer, about four percent of all cancer, kills almost 8,000 people yearly.

Tooth-saving knowledge which the public can get from their pharmacists includes health education for good oral hygiene, maintenance of good nutritional standards, dentally healthful dietary planning (including avoidance of sweet, sticky snacks), and periodic, selective self-examination with disclosing tablets.

The pharmacist can also furnish information for use by concerned citizens seeking fluoridation of the public water supply, Dr. Miller added, which has been shown to reduce cavities by 60-70 percent if drunk from birth.

Efforts can also be directed to assist segments of the population in need of special attention:

- Children — Therapeutic doses of tetracyclines can produce yellow-brown staining of permanent and deciduous teeth. Prolonged use of nursing bottles with sweetened formulas for pacification brings increased risk of cavities.
- Geriatric patients — Denture wearers require periodic visits to protect health of denture-bearing tissues. Toothless persons in this age group are at increased risk for neoplasms, especially heavy smokers and drinkers.
- Handicapped persons — Parents and others who care for the handicapped should be conscientious in getting dental care for their charges to avoid pain, infection, and premature tooth loss, which would complicate the handicap unnecessarily.

At the pharmacy, Dr. Miller continued, individuals can find the armamentaria necessary to remove dental plaque, new adjuncts to oral hygiene, fluoride dentifrices and additional reinforcement of motivation to seek dental health care.

National Survey to Determine Pharmacy Standards of Practice

Five thousand pharmacists nationwide will be asked to participate in a survey to determine the basic responsibilities which comprise the practice of pharmacy.

The survey is part of the first phase of the American Pharmaceutical Association/American Association of Colleges of Pharmacy project to develop practice standards for the profession. An outgrowth of a recommendation of the AACP/APhA Task Force on Continuing Competence in Pharmacy, the survey is being conducted by the Educational Testing Service (ETS), Princeton, New Jersey.

The survey questionnaire will be mailed to a randomly selected sample of pharmacists early in 1977. The questionnaire was developed by ETS with input from an advisory committee of pharmacy practitioners who represent a diversity of practice settings and were chosen because of their expertise and recognized contributions in practice.

The survey is designed to gather information about the relevant and important aspects of the practice of pharmacy in the following categories:

I. Activities related to processing the prescription order.
II. Patient care functions.
III. General management and administration of the pharmacy.
IV. Inventory, record keeping and control.
V. Purchasing and receiving pharmaceutical supplies, drugs, and equipment.
VI. Personnel administration in the pharmacy.
VII. Education of the public and health care professionals.

Because the respondents will be asked to make certain professional judgments about the responsibilities involved in the discharge of their duties, approximately one hour will be required to complete the form. All information will be confidential and will be used only for the purpose of data analysis.

The data analysis is expected to provide information which will indicate the areas in which certain knowledge, abilities, and skills are essential for the practice of pharmacy. The responses of pharmacists to the survey will be used to build programs which will be used in educating and training pharmacists to achieve and maintain professional competency.

Because of the importance attributed to this activity, the two sponsoring Associations (APhA and AACP) are seeking the cooperation of all pharmacists who receive the questionnaire to respond promptly.

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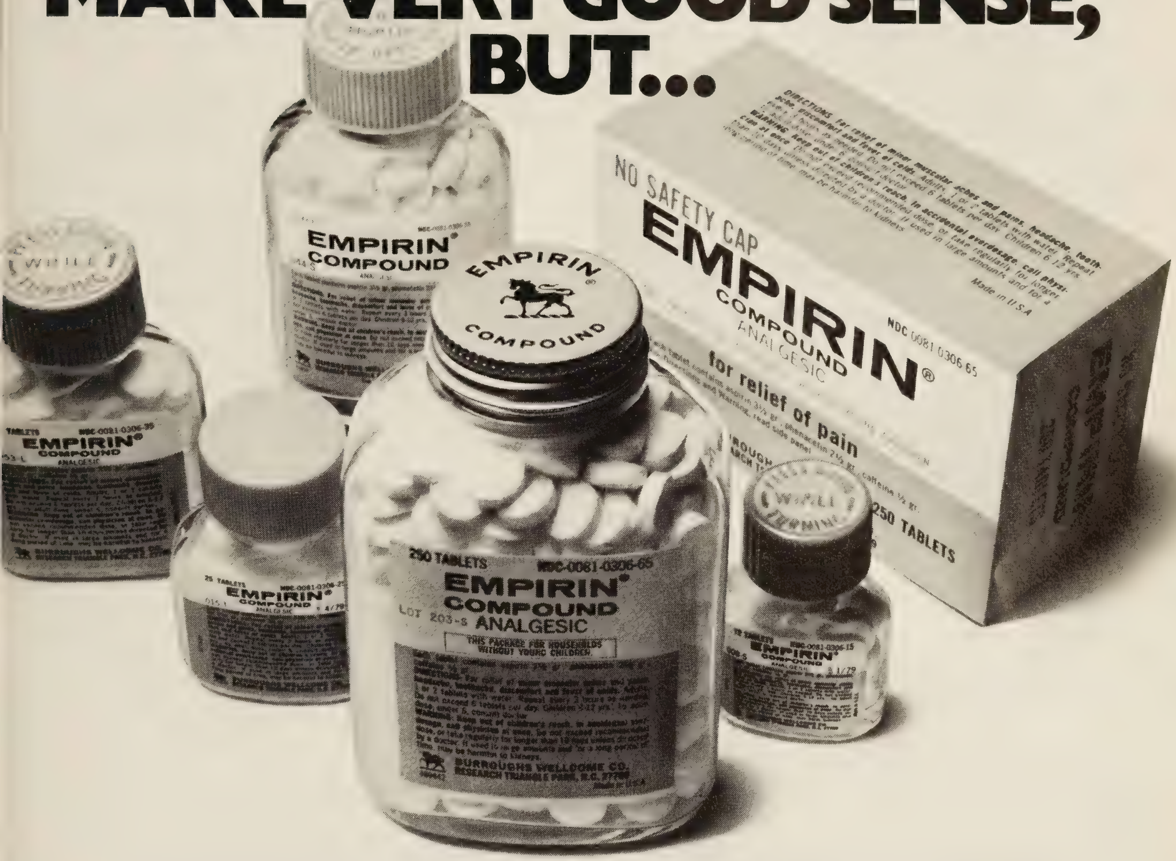
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Supportive Personnel *(Continued from page 11)*

Because of these realities about supportive personnel training and use, the AACP Professional Affairs Committee recognized that pharmacy education could no longer ignore the issue nor could it establish its own position and course of action in a vacuum. The Committee identifed a list of issues concerning supportive personnel upon which a consensus within the profession would be highly desirable and called for a broadly based task force as the *process* to begin developing a resolution of those issues. Unfortunately, the Committee, in writing its report[1] and presenting its case to the Association placed these issues primarily in the context of existing problems with supportive personnel training and utilization.

As a result, a natural reluctance to join in the task force was found on the part of some organizations because of concerns that a decision would be reached about supportive personnel that did not adequately interrelate with the realities of pharmacy practice needs today. Although the Committee intended the issues identified in the Report to be addressed and resolved in the larger context, this was not clearly stated.

Now, two years later, the issue of supportive personnel training and use is still a controversial one, and the number of technical schools and junior colleges taking independent action to train pharmacy supportive personnel is still increasing. It is my firm belief that pharmacy education and practice must work together at the national and local level to reach a consensus on the issues raised in the AACP Professional Affairs Committee Report. Also, being two years wiser as to the strategy for developing a *process for progress,* it would be my personal hope that the context in which these issues are discussed and considered be the needs of pharmacy practice today to continuously improve our effectiveness in meeting the pharmacy service needs of society.

---

[1] Chalmers, R. K., "Chair Report for the Committee on Professional Affairs — Supportive Personnel in Pharmacy," Amer. J. Pharm. Educ. **38**:741-748, 1975.

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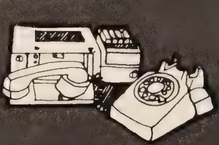

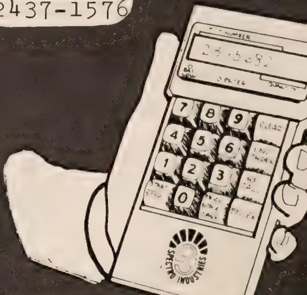

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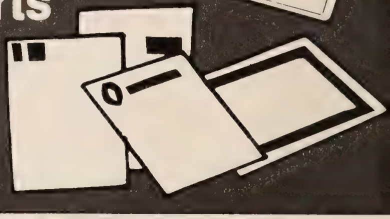

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BRUARY, 1977
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Medicaid:
Abuses/Quality/Fees

An Editorial

Future Utilization of Pharmacy Aides

Frank E. Kunkel

Why Become a Robbery Statistic

Thad L. Weber

THE MARYLAND PHARMACIST

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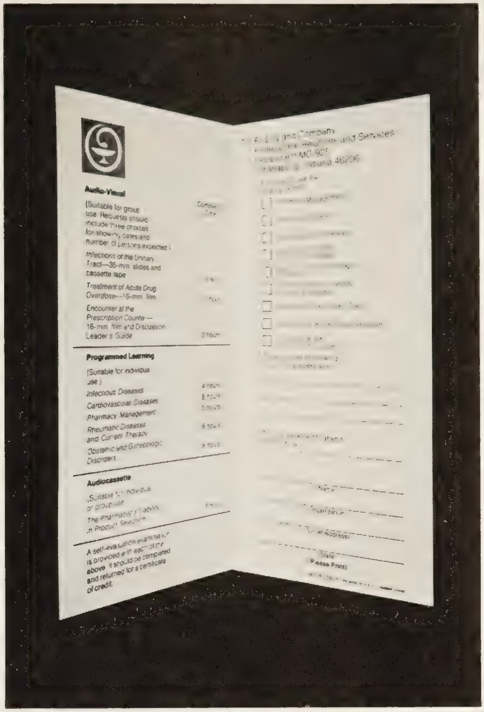
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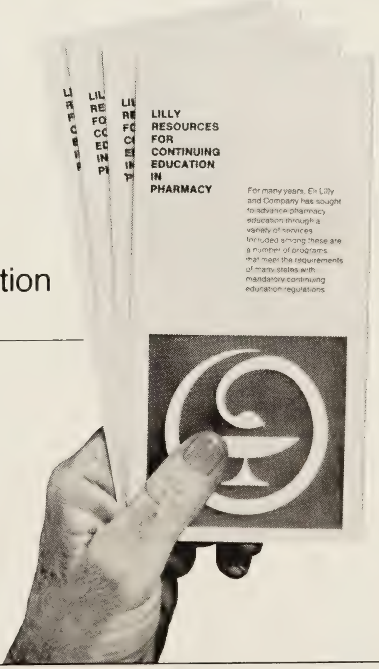
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Who Can Give Information About Drugs in a Pharmacy?

Because of legislation initiated and drafted by the Maryland Pharmaceutical Association only a pharmacist or pharmacy extern can give information about drugs and medicines and their therapeutic values, potential side effects, and uses in the treatment and prevention of diseases in Maryland. The bill was introduced by Delegate Torrey Brown, a physician.

The law in effect recognizes that in a pharmacy there is a specific health professional who is particularly qualified by education and training to counsel a member of the public who seeks information and guidance about medication.

By contrast, in establishments other than a pharmacy, the public is open to the dangerous practice of receiving advice and recommendations about drug therapy from clerks with no qualifications in providing health care. A host of the ''over-the-counter'' remedies so readily available in all kinds of outlets contain potent drugs, many of which require a physician's prescription in larger doses. Pharmacists should take every opportunity to educate the public that their health and often their very lives are at stake. When people seek advice from unqualified employees of emporia, such as supermarkets and variety stores, they are playing Russian roulette. Only in a pharmacy is there a person, as required by law, who is competent to answer the public's questions about drugs factually and to direct people to the proper medical practitioner as indicated.

In this issue of THE MARYLAND PHARMACIST you will find a poster suitable for display in pharmacies. We suggest that the poster be attached to a stiff cardboard or a sign with an easel back. Place this important message in a prominent place. Clerks in pharmacies can point to the sign as a backup for patrons requesting information. It will make referring them to the pharmacist on duty much easier. Over a period of time it will go a long way in getting the public to accept the fact that the pharmacy is the place to get medication because

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editorial

Medicaid: Abuses/Quality/Fees

Public disclosure and public scrutiny — public information "sunshine laws" — are the order of the day. Any profession or calling subject to state licensing is open to investigation and criticism. The files of governmental agencies at all levels must be made available to both the press and to citizens with valid purposes.

Accountability to the public is a particularly demanding responsibility for all the professions in the health care field. Today, as from time to time in the past, "Medicaid" — the federal-state Medical Assistance Program (Title 19) — is under attack for waste, inefficiency, fraud and abuse by both recipients and providers of service. Testimony at Congressional hearings and proposals for remedial action so far reveal nothing new. There is still a great deal of the "police" approach to the problems which are perceived. There is insufficient regard at both federal and state levels for the quality of care that should be provided. The recognition of quality care and establishment of reasonable fees for providing such care would go a long way to assure care of high standards. The end result could be health care that incorporates rational drug therapy in prescribing and dispensing medication. This includes decisions as to whether any drug product is indicated after diagnosis, selection of a drug product, quantity, dosage regimen, advisability of refill instructions, pharmacist drug product selection, drug therapy monitoring, individual patient medication profile systems, patient counseling and followup regarding drug therapy and any other services that would be beneficial under "clinical pharmacy" services. A true physician-pharmacist health care relationship is implicit.

Such a development would require not only a fee schedule for reimbursement of traditional pharmaceutical service, i.e., compounding and dispensing of prescriptions. There would also have to be a method for reimbursement for some of the other services enumerated above, whether or not a drug product was dispensed. Compensation should also be authorized for services based upon the availability and application of professional knowledge and expertise.

Are these proposals realistic on a cost accounting basis? If the allegations of several *billion* dollars lost annually due to fraud and abuse are true, then procedures which will help to remedy the problems should make funds available to be shifted to some constructive programs to improve health care.

In the meantime, pharmacists must give attention to allegations of submitting improper invoices for payment or for collusion with prescribers and nursing homes.

Almost all of the pharmacies in Maryland participate to a large or small degree in the Medicaid Program. The overwhelming majority comply with the spirit and letter of the laws, regulations and guidelines. They conscientiously try to serve the best interests of the patients. The few who seek to exploit patients or defraud the program (financed by taxpayers) must be dealt with promptly and forthrightly in order to maintain the good name of the profession and of ethical, law-abiding pharmacists.

– Nathan I. Gruz

calendar

April 17 (Sunday) — AZO Fritz Berman Seminar, Holiday Inn, Baltimore Beltway Exit 17

April 17 (Sunday) — Eastern Shore Pharmaceutical Society Spring Dinner Meeting, Dockside Murphy's Restaurant in Salisbury

April 21 (Thursday) — MPhA Regional and House of Delegates Meeting, Friendship International Hotel

April 26 (Tuesday) — Anne Arundel County Pharmaceutical Association Meeting, "The Use of Auxiliary Labeling Systems For Providing Patient Information", Sheraton Motor Inn, Silver Spring, Maryland

May 15-19 — APhA Convention, New York City

June 2 (Thursday) — University of Maryland School of Pharmacy Alumni Banquet, Eudowood Gardens

June 17-19 — Maryland Society of Hospital Pharmacists Seminar, Sheraton Hotel, Ocean City, Maryland

June 19-22 — Maryland Pharmaceutical Association Annual Convention, Carousel Hotel, Ocean City, Maryland

Future Utilization of Pharmacy Aides*

By Frank E. Kunkel†

I want to thank the Alumni Association of the University of Maryland School of Pharmacy and the Maryland Pharmaceutical Association for inviting me to participate in this first memorial lectureship in honor of Francis Balassone. My acquaintance with Frank came about through our membership in the National Association of Boards of Pharmacy and he was a very good friend and advisor, both to me and my board on many occasions. It is a distinct honor to be permitted to share in recognition of a very important pharmacist in the history of our profession.

Presuming to express the viewpoint of pharmacy boards and the profession-in-general on the topic of pharmacy aides appears to me to be a most irrational venture. The only agreement on this subject I have been able to discover is that there is no agreement among boards, professional associations, various categories of practitioners, educators or the public. Neither, it seems to me, is there any shortage, among these divisions of pharmacy, of articulate and outspoken proponents and opponents of the use of supportive personnel and, in Ohio, many of these come equipped with typewriters or have my office and home telephone numbers, so I have heard plenty of testimony on both sides of the issue.

It is now ten years since I first put pharmacy technicians on my board's meeting agenda for consideration and a quick solution, and you may get an idea of the dispatch with which it handled the problem when I tell you that it will be there again when the board meets in December. Now, however, the cushion of time has expired and the time for decision — at least in my state — has arrived.

The junior and branch colleges and technical schools in Ohio will graduate about fifty technicians or technologists next summer and an increasing number thereafter. Alumni from these institutions are beginning to make their presence known by appearing in our inspection reports as, for example, one I received last week which stated "The technologist receives the order for an intravenous additive solution, performs the calculations and compounds the product which is then checked by the responsible pharmacist." Obviously, the number of technicians I quoted is only those persons we know about or encounter in such reports and it is impossible to estimate how many others are out-of-sight and knowledge.

At this point in my comments on pharmacy aides, I have already referred to them as supportive personnel, pharmacy technicians and technologists and I still have a few titles left, such as a paraprofessional, pharmacy clerk and assistant, prescription department clerk and apprentice and non-pharmacist which may appear later. In the interest of better understanding, I should make it clear at the beginning that I speak of pharmacy aides as the entire group of persons, regardless of title, who are involved with the practice of pharmacy, but are as yet almost totally unrecognized or approved by the statutes or rules that regulate the profession.

This brings me to a most important consideration on this topic and that is the relationship of Boards of Pharmacy to the whole concept of recognizing a category of persons in practice which is not recognized in law. A regulatory board's single most important duty is protection of public health and welfare and it must be in the context of that responsibility and the implied intent of the legislature that it decides what it can and will approve for change in traditional procedures. This is not to say that boards shouldn't or won't eventually recognize pharmacy aides but it does mean that once the profession reaches a consensus of opinion about these persons and can endorse their recognition as being in the public interest, the idea must be run through the same legislative process that the existing statutes followed before a particular board can adjust its enforcement practices to accommodate the wishes of the practitioners.

This, in my view, is the friction point between the boards and the professions we have today. To demonstrate this with a practical example, I refer again to our inspector's report on the technologist-prepared I.V. additive solution. The statutes define "the practice of pharmacy as compounding and dispensing of drugs" and the regulations further expand on this definition by stating compounding to be the mixing of two or more drugs and dispensing to consist of the minimal required professional action and judgments to assure the patient of an accurate and reliable prescription. There is no mention of a pharmacist supervising or checking a pharmacy aide's work and no way a responsible pharmacy board can read this into the law and approve such practice. Obviously, the pharmacist who instituted this procedure and his administrator consider it perfectly safe for the patient and economically sound for the institution, but the board must have serious reservations about it based on its experience and records of complaints when similar systems of supervision and checking have failed to protect the patient from medication error.

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*Presented at the Francis S. Balassone Memorial Lecture, November 18, 1976.

†Mr. Kunkel is President, National Association of Boards of Pharmacy.

This much we know. Supervising and checking another person's work is a terribly dull and boring occupation which becomes even more dull and boring when the aide's performance and reliability is practically perfect. Finding fault or searching for error is hardly the most stimulating challenge to a pharmacist's abilities and the absence of supervision as a subject in a college curricula leaves this otherwise management skill pretty much up to the natural ability and interest of a particular pharmacist. If my pharmacy board judges such a checking procedure by its experience with the legally authorized supervision of a pharmacy intern by a pharmacist-preceptor, it has evidence enough to become very uneasy about the patient's welfare under the pharmacy aide-pharmacist relationship.

I believe I have heard most if not all of the arguments which are offered to counter such a conclusion. One, no pharmacist is going to permit a clod to mess up his professional reputation with asinine errors. Two, persons other than pharamcists, hopefully registered nurses, have been compounding I.V. additives for years without great concern or reaction from boards of pharmacy. Three, if a pharmacy department is going to assume total responsibility for all preparation and distribution of all drug products, there simply is not enough manpower available to staff the operation. Four, it is economically unfeasible and professionally impractical to waste the unique knowledge and skills of a pharmacist on mechanical or manipulative procedures which, it can be demonstrated, may be done as well by a trained aide and, these numbers and arguments can go on ad infinitum.

Failing to be constantly aware of the patient's health and welfare can be a fatal and costly oversight.

Interestingly enough, these are all valid arguments with which a board may agree but they overlook one most important consideration and that is they are not approved as legal. In this current era of consumer-protection followed by malpractice claims, if it breaks down, I can't help wondering what the viewpoint of insurance underwriters on this topic may be or if they are even being consulted. It seems to me, and calls from plantiff's lawyers confirm this, that in an instance of harm to a patient resulting from an identifiable illegal act by a technician or a pharmacy aide, the responsible institution and/or pharmacist could find themselves standing alone before the bar of justice in a civil action. Failing to be constantly aware of the patient's health and welfare can be a fatal and costly oversight.

I have previously stated that my board will shortly have to come to grips with the problem of pharmacy aides. A few other pharmacy boards have already done this and a brief review of pharmaceutical publications reveals that the Michigan Board in cooperation with the other members of a tri-partite committee has recognized use of supportive personnel and promulgated a set of rules specifying their duties and setting their ratio to registered pharmacists. I believe Delaware may have a similar set of regulations.

Illinois seems to have progressed farthest by registering supportive personnel as apprentices for a modest fee and giving them official approval to handle drugs under the supervision of a pharmacist. *Drug Topics*, in May of last year, reported activity by the boards and state pharmaceutical associations in Massachusetts, California and Nevada much further advanced toward solution of this problem than my own state or others which are either just now taking a closer look at the matter or continuing to ignore it altogether.

NABP Position on Pharmacy Aides

Naturally, the National Association of Boards of Pharmacy has been sensitive to the concerns of its constituent members about this matter and responded as far back as 1971 with a report on professional roles to its annual meeting. This report was reinforced in 1972 when the Executive Committee of NABP requested a joint meeting of its bureau of law enforcement and committee on institutional pharmacy to consider again specific roles for both pharmacists and supportive personnel.

The final report of that committee, under the chairmanship of Paul Grussing of Minnesota, is the official position of NABP on the matter of pharmacy aides so I quote those sections of the report which are applicable to the subject of our interest this evening and, I may add, which have not had wide publication and distribution outside of Boards of Pharmacy.

Of particular concern to the joint committee was emergence recently of associate degree programs for supportive personnel positions. Adding to this concern is the vulnerability of our profession to non-professional groups who would seek full professional recognition via legislation.

Should innovations in certain jurisdictions create supportive personnel, educate them and grant them licensure status, the experience of state legislatures and boards of pharmacy provide us with a number of examples of successful attempts by non-professionals at attaining full legal professional status by legislative action rather than by education.

This general concern by members of the joint committee relates largely to the image of our profession in the minds of the various public policy makers. This image does not coincide with the aims of innovators who are seeking to change roles of pharmacists, and it does not coincide with institutional practice which is generally not visible to the public policy makers. Pharmacy has one dominant image in the minds of our public policy makers — that of the community practitioner. Therefore, if new modes of practice, for example, clinical pharmacy, are to be appreciated by the public and understood by legislators, these new modes of practice must be widely accepted and understood within the pharmacy community. Without a clear evolution in all types of practice there can be no public and legislative understanding and support for redefinition of pharmacy practice roles.

A clear legislative fact of life is that pharmacists are often seen as being professionally educated practitioners in a technical role. Without the necessary general acceptance, maturity and sophistication of new practice roles, it will be difficult to communicate their importance to legislators. At the present time, these roles are still not visibly apparent and are generally attributed to the prescriber alone. So, in spite of the fact that today's pharmacist is probably the best-informed drug expert among health care professionals, and in spite of the exciting new roles which are beginning to maximize the utilization of the pharmacist's knowledge, we, as a profession, are viewed largely not as professionals but as technicians.

The joint committee is extremely hopeful that inter-professional acceptance of new roles will be accelerated so that certain duties now considered to be reserved for pharmacists only might safely be delegated at a time when pharmacists can be professionally and legally secure in their new roles. What the joint committee has feared most is the spectacle of placing the cart before the horse as is the argument that supportive personnel will free pharmacists for utilization in guaranteed new roles which are fully accepted by other health professionals. Boards see a fallacy in the presumption that general inter-professional and public recognition of new clinical roles already exists and that sandwiching a layer of non-professionals below today's pharmacists would force the capabilities, utilization and acceptance of the pharmacist upward. The fear is that if this occurs prematurely, the non-professional could displace the pharmacist, who, if he would not be allowed to perform new roles, would have to return to his former mechanical roles, only to find them in the hands of the non-professionals.

With these concerns in mind the joint committee examined and reviewed reports of the task force on practitioners and sub-professional roles in pharmacy. It sought to identify those roles which are clearly non-professional in nature and which can now safely be delegated to non-professionals.

It divided them into two classes, the first of which listed roles which a non-pharmacist may perform according to policies and procedures established by a pharmacist and limited the list to duties involving mechanical, clerical and secretarial responsibilities not directly involved with the patient or his medication. In other words, the duties which historically have been assigned to the handiest and least expensive employee.

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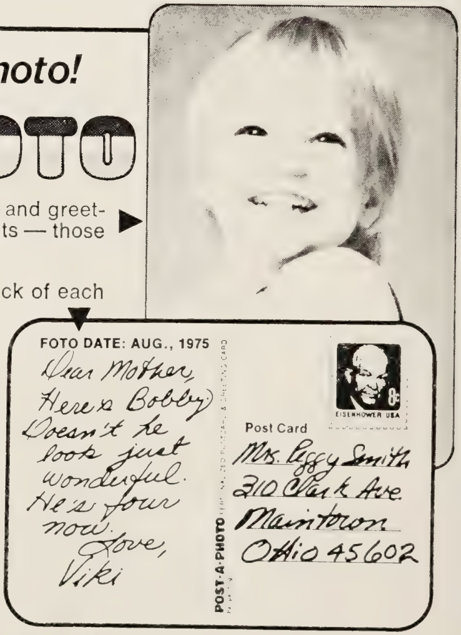

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The committee then set the intermediate level between the pharmacist himself and this first class of aide by listing roles which a non-pharmacist may perform according to policies and procedures established by a pharmacist but only when under his close personal control and supervision. These duties are those involving manufacturing, i.e. bulk compounding, pre-packaging and labeling, and maintenance of drug control and accountability records, as well as patient medication profiles.

In my experience, this is the category of pharmacy aide which presents the greatest problem because of the relatively short distance to cross that invisible line which separates supportive activities from the real practice of pharmacy. It is also the area wherein the laws and regulations do not invariably speak as clearly as they should. I don't believe a pharmacy aide holding an associate degree or a document certifying to his competency to perform twenty-five different duties will be satisfied for long if a supervisor-pharmacist only permits him to do fifteen. If a pharmacist is the least bit willing, he will inevitably cross the line, and unfortunately, too many pharmacists are seemingly, more than willing.

A good bit of what I have said here will be recognized as a retread of observations made previously and better by other commentators on this topic. What I have missed hearing or reading to date, however, has been consideration by anyone of some of my own special concerns about pharmacy aides.

Concern for Pharmacy Interns

First and foremost is my concern for our pharmacy interns. As our college enrollments have increased and job opportunities remained nearly static, many of these young people are having increasingly difficult times finding the positions so necessary to their qualification to become pharmacists. Will some of the most desirable training sites for externs be manned by these aides who, at the least, will be available on a daily basis and at the times supportive help is most needed? If one of our Ohio pharmacists' experience is any example, the U.S. Department of Labor will not permit interns to work without pay even though this may be their last resort to accumulate their internship hours requirements. Are we, in fact, suggesting that these legally authorized practitioners be replaced by a new category of employee which is already giving us problems? Interns and externs have a real interest in the final decision but I don't see them having much input to the decision-making process.

Another of my concerns is the increasing number of foreign-graduate pharmacists who have come to this country and established citizenship and residence with the expectation of making a new life for their families and career for themselves. With the exception of the state of New York, all they are finding is barriers and very little sympathy or assistance. Unless we are descendants of native American Indians, some one of our ancestors must have followed this same path to make it possible for us to be what and where we are today. The question is—do they have a better claim for our attention rather than the cheap help who can hardly expect to rise much above their starting occupations as supportive personnel? I am absolutely certain we cannot continue to ignore these people and the day is not far off when we shall have to move over and take them in. Many of these pharmacists can or, with a minimum of additional schooling will, meet our professional standards and, instead of just soaking up the available job openings may make it possible for the profession to insist that a pharmacist be in every situation in which a pharmacist should be. I don't see the recognition of pharmacy aides as contributing a great deal to the total advancement of the profession simply by freeing a relatively small percentage of our practitioners from duties many of them prefer in the first place.

As I conclude this presentation, I cannot help thinking how wonderful it would be to have the wisdom and experience of Frank Balassone to help us reach a practical solution to a sticky problem as we so often did during his long and distinguished career. I only hope this meeting will move us toward some answers with which he would have agreed.

This is the concluding paper of the Balassone Memorial Lecture Program. Previous papers were published in the December 1976 and January 1977 issues of THE MARYLAND PHARMACIST.

Lot Number Requirement Changed For Unit Dose Hospitals

The Bureau of Health Insurance recently announced a change in policy which affects hospital pharmacies dispensing drugs in unit dose packaging or unit of use packages. These hospitals will no longer be required to record lot numbers. The medication, when dispensed in its original package, is identified by lot number on the manufacturer's original label.

This new policy, which resulted from a petition from the American Society of Hospital Pharmacists to then-Secretary of HEW David F. Matthews, should eliminate the administrative delays and unnecessary patient care costs created by the requirement.

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therapy.

Adverse Reactions: Commonly observed side
effects include nervousness and tremor. Other re-
ported reactions include headache, increased hea
rate, palpitations, drowsiness, nausea, vomiting, a
sweating. These reactions are generally transient

eigy

usually do not require treatment and appear minish in frequency with continued therapy. In eral, all the side effects observed are characteristic hose commonly seen with sympathomimetic amines. **How Supplied:** Round, scored, white tablets of g. in bottles of 100 and 1,000 and Unit Dose Packs of 100; oval, scored, white tablets of 2.5 mg. in es of 100.
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Pharmacy Changes, July-November

Maryland Pharmaceutical Association is no longer regularly provided with official notices of pharmacy changes (openings, closings, change of ownership, change of address). The following list has been compiled from the best information available for the period indicated.

New Pharmacies

K Mart #3167, E.E. Wardlow, President; 5760 Wabash Avenue, Baltimore, Maryland 21215

Giant Pharmacy #246, J.B. Danzansky, President; 5150 Sinclair Lane, Baltimore, Maryland 21206

The Prescription Shoppe, Hillel and Barbara Aarons, President; 9101 Franklin Square Drive, Baltimore, Maryland 21237

Peoples Drug Store #77, William J. Johnson, President; 225 North Washington Street, Rockville, Maryland 20850

Read's, Inc. #81, Arthur K. Solomon, President; Tred Avon Shopping Center, Easton, Maryland 21601

Read's, Inc. #82, Arthur K. Solomon, President; 6404 Ridge Road, Sykesville, Maryland 21784

Dart Drug Corporation #244, Herbert Haft, President; Route 50 & Tilghman Road, Salisbury, Maryland 21801

Dart Drug Corporation #232, Herbert Haft, President; 6510 Baltimore National Pike, Baltimore, Maryland 21228

Boonsboro Pharmacy, Gary Haas; 2 North Main Street, Boonsboro, Maryland 21713

K Mart Pharmacy #3256, E.E. Wardlow, President; North Plaza 8980 Waltham Woods, Baltimore, Maryland 21234

Hill's Drug Store, Inc., William C. Hill, President; Dutchman's Lane, Route 3, P.O. Box 126, Easton, Maryland 21601

Giant Pharmacy #247, J.B. Danzansky, President; 1131 Merritt Blvd., Dundalk, Maryland 21222

Giant Pharmacy #248, J.B. Danzansky, President; 9550 Livingston Road, Oxon Hill, Maryland 20022

Change of Ownership

Kay Cee Drugs, Myles Kaye, President; 6609 Riverdale Road, Riverdale, Maryland 20840

Star O'Nevins Drug Store, Irvin Silen, President; 5814 Belair Road, Baltimore, Maryland 21206

Marek Pharmacy, Larry Kelly and Elizabeth Newcomb; 701 North Lakewood Street, Baltimore, Maryland 21205

McAlpine Pharmacy, Daniel Shaner, President; 9141 Baltimore National Pike, Ellicot City, Maryland 21043

Levay Pharmacy, William Batt; 1458 Riverside Avenue, Baltimore, Maryland 21230

Harford Pharmacy, James Brinsfield; 804 Conowingo Road, Bel Air, Maryland 21014

Idelwood Pharmacy, Norton Grossblatt, Kurt Sacki, and Peter Hirsch; 6305 Sherwood Road, Baltimore, Maryland 21231

Change of Address

Cloverly Drugs, 15521 New Hampshire Drive, Silver Spring, Maryland 20904

Paradise Pharmacy Inc., 6350 A Frederick Road, Catonsville, Maryland 21228

Closed Pharmacies

MacLarty's Pharmacy, 537 E. 41st Street, Baltimore, Maryland 21218

Kahn Pharmacy, 1722 Wilkens Avenue, Baltimore, Maryland 21223

Welsh Pharmacy, Berlin Shopping Center, Route 50 & Route 346, Berlin, Maryland 21811

C & P Professional Pharmacy, 8605 George Palmer Highway, Glen Arden, Maryland 20801

Peoples Service Drug Store #88, 2 North Washington Street, Rockville, Maryland 20852

Read's, Inc. #33, 24 North Washington Street, Easton, Maryland 21601

Green's Pharmacy, 18 West Bel Air Avenue, Aberdeen, Maryland 21001

Sentry Drug, 1818 Virginia Avenue, Hagerstown, Maryland 21740

The 1977 Lilly Digest

The Lilly Analysis Service has recently mailed forms to all independent community pharmacies inviting their participation in the 1977 Lilly Digest. The Service is designed to assist community pharmacists in better understanding and evaluating all information that defines the management of independent pharmacy practice. The analysis is free of charge and data submitted will be held in strict confidence.

The usefulness of the publication, *Lilly Digest*, is dependent upon the extensive participation of retail pharmacy. A good return of completed forms will enhance the reliability of the *Digest* and its comparative operating statistics.

In addition to generating a national standard for effective pharmacy management, the Lilly Analysis Service will also offer personal commentary regarding important aspects of each owner's operation and how it may be enhanced.

Plan NOW to attend the MPhA Annual Convention at Ocean City in June.

Quaint? Well, in the year 2052 A.D. how old-fashioned will today's pharmaceutical manufacturing facilities seem?

Make no mistake: seventy-six years ago there was nothing quaint or nostalgic about Dr. W. C. Abbott's granule manufacturing operation. At the turn of the century, when this photo was taken, this was as modern a pharmaceutical producing facility as could be found anywhere in the world.

A look at Abbott's past is a key to Abbott's present. When Dr. Abbott founded the Abbott Alkaloidal Company in 1888, he set innovative standards for his products. Early on, pharmacists and physicians learned to expect uncompromising quality in every pharmaceutical product that bore the Abbott name.

These standards are still inherent in every phase of every product made by Abbott Laboratories . . . now more than a half dozen divisions, nationwide, worldwide, with sales exceeding a billion dollars annually.

Chances are that in the fifties . . . the *twenty*-fifties . . . they'll be showing quaint, nostalgic photographs of what we see as today's sleek, computerized pharmaceutical manufacturing facilities. They'll seem hopelessly primitive to the pharmacists and the physicians of that future era. But traditions . . . Abbott traditions . . . being what they are, we're confident that those pharmacists and physicians can look to Abbott quality just as folks did in the good old days of the nineteen-seventies.

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Why become a robbery statistic?

by Thad L. Weber, Security Consultant, SK&F Laboratories

The Prognostication. Contrary to the opinions of wishful thinkers, statistics are what happens to you and me, under *average* conditions. And, in line with recent studies of crimes against pharmacies, the statistics predict:

- Your store will be the target of an armed robber at least once in the next 6 years.
- The robber will most likely attack after 6:00 p.m.
- Money will be the attacker's primary objective.
- In 3 out of 4 attacks, the criminal will escape and will not be apprehended or convicted.
- The odds you will get the stolen money or property back are less than 1 in 100.
- One in 20 shopkeepers will be injured or killed in such attacks.

And before you apply any educated guess to these statistics, let's make it clear that these crime rates, while higher in urban environments, are rapidly climbing in suburban areas and apply equally to independently owned or chain pharmacies.

Changing the Odds. While you cannot escape becoming a part of the crime statistics, you can *deter* robbery attacks by applying security measures that make for "short odds" the criminal can't stomach. The most effective crime prevention program is one which is within your business necessity budget, includes physical and/or electronic security devices, and effective security procedures—all custom-tailored to best suit your needs. Therefore, the following suggestions are intended simply to serve as a shopping list from which you can select your security-against-robbery menu.

Deterring Escape. In addition to the use of electric door lock releases, improved visibility and special lighting, to be discussed in a future column, robbery planning may be discouraged when escape routes are limited or impeded by:

- Installing security bars on rear or side window openings.
- Restricting all "visitors" to the customer retail area (so they can't size up the ease or difficulty involved in leaving through any existing emergency exit).

Thad L. Weber

- Exit turnstiles which slow down departure.
- Barriers or gates which obstruct efforts to move behind the counter.
- "Dead" locks on all doors not required as fire emergency exits.

Smile—You're on Candid Camera. Many retailers, even those in the highest risk and crime areas, have reduced their robbery exposure by installing:

- Closed circuit TV.
- Automatic surveillance cameras.

Reduce the Target Size. Since money is the primary objective, the would-be attacker who observes that little money is kept in a readily accessible cash register is likely to look elsewhere for his victims. And you can make up his mind for him by:

- Making frequent bank deposits over busy street routes during normal business hours.
- Conducting business for check or credit card payments only during restricted evening hours.
- Installing small money drop safes secured in concrete or firmly affixed to the building structure (so they can't be carted away) and establishing procedures wherein employees working alone or at night do not possess keys or combinations to such safe locks.
- Scheduling armored car company pickups if the cash flow is a large one.

And remember, whatever you do to reduce the amount or accessibility of cash on hand, you must, as do others, "advertise"—notices such as, "Exact change or credit cards" are signs of the times, which you should adopt or adapt to suit your security needs against robbery.

Speedy Police Response Is a Deterrent. And while you can't control this factor, the *presence* of fixed and wireless silent holdup alarm signal devices is a *deterrent* to the robber since he recognizes that activation of a device *may* bring police to the scene before he can escape.

In a future column we'll discuss holdup alarm systems in detail, but meanwhile, if you use a holdup alarm system, make sure there are decals on the entry door to alert the criminal to his danger!

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Patient Counseling and Drug Interaction Literature

The following bibliography, compiled by the University of Maryland School of Pharmacy, Department of Continuing Education, represents available literature for the practitioner in the areas of patient counseling and drug interactions. This list was presented at the joint MPhA-MSHP meeting of January 13, 1977.

Patient Counseling:

1. Steven Strauss, "Patient Dosage Information", 3rd Ed., IMS America Ltd., Ambler, PA 19002 (1975). ($6.95)
2. Scott Apelgren and Brandt Rowles, "CLINICAL PHARMACY HANDBOOK FOR PATIENT COUNSELING", Drug Intelligence Publications, Inc., Hamilton, Ill. 62341 (1975) ($12.00)
3. J. Knoben, P. Anderson and A. Watanabe, "HANDBOOK OF CLINICAL DRUG DATA", Drug Intelligence Publications, Hamilton, Ill. 62341 (1973) ($4.75)
4. "The United States Pharmacopeia", XIX Rev., United States Pharmacopeial Convention, Inc., Rockville, Md. 20852 (1975)
5. John Runyan, Jr., "Primary Care Guide", Harper & Rowe Publishers, Hagerstown, Md. 21740 (1975)

Card Files;

1. "PHARMEX Drug Reference Center", Automatic Business Products Co., Willimantic, Ct. 06226 (1976)
2. "Drug Consultation Guide", Drug Intelligence Publ., Hamilton, Ill. 62341 ($49.95)

Drug Interactions:

1. "EVALUATIONS OF DRUG INTERACTIONS", 2nd Ed., American Pharmaceutical Assoc., Washington, D.C. 20037 (1976) ($8.75 — APhA Members, others ($12.50)
2. Philip Hansten, "DRUG INTERACTIONS", 2nd Ed., Lea & Febiger, Philadelphia, PA (1973)
3. Edward Hartshorn, "Handbook of Drug Intelligence Publications, Hamilton, Ill. 62341 (1973) ($5.85).

Other:

1. Robert Dreisbach, "Handbook of Poisoning", 7th Ed., Lange Medical Publications, Los Altos, Calif. (1971).
2. "Bugs and Drugs — Nineteen 76", Bugs and Drugs, Inc., University City, Mo. 63130 (1976)
3. "Patient Medication Profiles", American Pharmaceutical Assoc., Washington, D.C. (1975), available from Md. Pharmaceutical Assn.

Lay Publication:

1. Edward Stern "PRESCRIPTION DRUGS AND THEIR SIDE EFFECTS", Grosset and Dunlap, New York, N.Y. (1975)

Amphetamine Abuse Under Close Scrutiny by FDA

The Food and Drug Administration (FDA) recently told Congress that if current studies document a continuing and serious abuse of amphetamines, a widely-used class of anti-obesity drugs, then the FDA would either withdraw approval for use of the drugs in treating obesity or remove the drugs from the market altogether.

Dr. J. Richard Crout, director of the FDA Bureau of Drugs, testified before a Senate Hearing chaired by Senator Gaylord Nelson that the FDA anticipates that information being developed by the Drug Enforcement Administration (DEA) will provide the legal evidence of abuse necessary to support future FDA regulatory action.

The most common medical use for amphetamines, often called "pep pills," is in short-term programs of weight reduction. Less common uses are for the treatment of narcolepsy (a rare condition of uncontrollable sleepiness) and for minimal brain dysfunction (hyperactivity) in children. Other drugs are available for these uses.

Dr. Crout said that the FDA and the National Institute of Drug Abuse (NIDA) are cooperating with DEA in its efforts to document the abuse problem.

Dr. Crout said that the removal from the market of approved drugs, such as the amphetamines, on the basis of widespread abuse, rather than safety risk to individual patients, "would be an innovative position for which there is little legal precedent."

He added, however, that "we believe such a position is legal and we are prepared to defend it."

The FDA has, for a number of years, supported strong controls on the amphetamines. In 1972 an expert advisory group to FDA determined that the amphetamines made only a "trivial contribution" to weight-reduction programs and the FDA immediately tightened physician labeling requirements to reflect this judgment and also to highlight the potential of the drugs for abuse.

With FDA concurrence, the DEA has for five years listed the amphetamines in the most restrictive category available under the Controlled Substances Act.

This category, Schedule II, is reserved for medically useful drugs that have known potential for abuse. Morphine and other opium products are in this schedule. Production, distribution and sale of Schedule II drugs is strictly limited. Prescriptions may not be refilled and manufacturers must limit production according to DEA-established quotas.

These scheduling and labeling regulations have resulted in an 80 per cent reduction in annual use of amphetamines when compred to the peak year of 1965.

Evidence indicates, however, that the amphetamines remain the most seriously abused of all anorectic (appetite suppressant) drugs.

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          2437-1576
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NDC    68
0123-61
  5D70
 1 032
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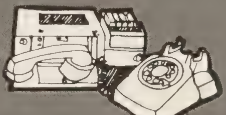

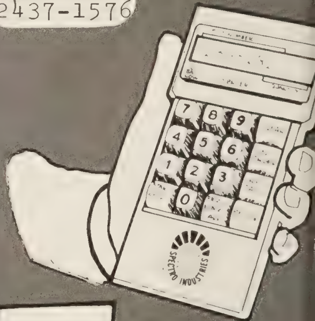

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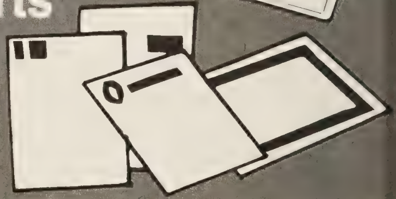

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Code of Ethics *American Pharmaceutical Association*

Preamble

These principles of professional conduct for pharmacists are established to guide the pharmacist in his relationship with patients, fellow practitioners, other health professionals and the public.

A Pharmacist *should hold the health and safety of patients to be of first consideration; he should render to each patient the full measure of his ability as an essential health practitioner.*

A Pharmacist *should never knowingly condone the dispensing, promoting or distributing of drugs or medical devices, or assist therein, which are not of good quality, which do not meet standards required by law or which lack therapeutic value for the patient.*

A Pharmacist *should always strive to perfect and enlarge his professional knowledge. He should utilize and make available this knowledge as may be required in accordance with his best professional judgment.*

A Pharmacist *has the duty to observe the law, to uphold the dignity and honor of the profession, and to accept its ethical principles. He should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession.*

A Pharmacist *should seek at all times only fair and reasonable remuneration for his services. He should never agree to, or participate in, transactions with practitioners of other health professions or any other person under which fees are divided or which may cause financial or other exploitation in connection with the rendering of his professional services.*

A Pharmacist *should respect the confidential and personal nature of his professional records; except where the best interest of the patient requires or the law demands, he should not disclose such information to anyone without proper patient authorization.*

A Pharmacist *should not agree to practice under terms or conditions which tend to interfere with or impair the proper exercise of his professional judgment and skill, which tend to cause a deterioration of the quality of his service or which require him to consent to unethical conduct.*

A Pharmacist *should strive to provide information to patients regarding professional services truthfully, accurately, and fully and should avoid misleading patients regarding the nature, cost, or value of the pharmacist's professional services.*

A Pharmacist *should associate with organizations having for their objective the betterment of the profession of pharmacy; he should contribute of his time and funds to carry on the work of these organizations.*

Approved by APhA Active and Life members August 1969
Amended December 1975

Approved by Maryland Pharmaceutical Association Board of Trustees,
February 3, 1977

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Pharmacy Inspection Procedures BMPA Meeting Feature

The Baltimore Metropolitan Pharmaceutical Association meeting of February 1, 1977 at the Quality Court, Pikesville, featured guest speaker Donald H. Noren, Director of the Environmental Health Administration, Maryland State Department of Health and Mental Hygiene. Greetings were brought by BMPA president Stanley J. Yaffe who then introduced Mr. Noren. Speaking without a prepared text, Mr. Noren briefly discussed the function and operation of his agency. Following the presentation, questions and comments were entertained from those in attendance. Many pharmacists voiced dissatisfaction with the current check list system for pharmacy inspections employed by the Division of Drug Control. Mr. Noren agreed to meet jointly with members of MPhA to discuss specific items within the inspection procedure.

During the discussion period Mr. Noren stated that if an inspector visited a pharmacy during a particularly busy time for the pharmacist in charge he could be asked to return a mutually satisfactory time. He also stated he would discontinue the requirement for a written reply from a pharmacy owner as to corrective action that would be taken for infraction's found by an inspector.

The BMPA business meeting followed with a report by Executive Director Nathan Gruz on the legislature regarding the status of bills. Prescription Insurance Programs Committee Chairman Marvin Friedman presented an update on third party matters particularly Medicaid.

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Nathan I. Gruz, Editor
Maryland Pharmacist
560 West Lombard Street
Baltimore, Maryland 21201

APhA Memorandum on Third Party Activities

The following letter written by Carl Roberts, Associate General Counsel of APhA, responds to the urgings of many pharmacists for the Justice Department to investigate possible illegal price fixing among third party payment programs.

You recently referred to me a letter from an APhA member complaining about a particular third party payment program administrator and urging that APhA bring the "price fixing" activities of this organization to the attention of the Justice Department.

The letter to which I refer is similar to many communications received from pharmacists who label the contract offers of third party payment programs as "price fixing" and argue that APhA should take action against what they believe to be unlawful conduct.

While the specifying of a price that a third party payment program is willing to pay for pharmaceutical service may be characterized in the general sense as "price fixing", it does not, standing alone, constitute unlawful "price fixing". Neither the unilateral establishment of a price to be paid by a buyer of goods or services or the unilateral establishment of a price to be charged by a seller of goods or services constitutes "price fixing" within the scope of Section 1 of the Sherman Act or other antitrust laws.

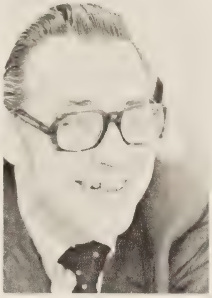
Thus, when a pharmacist establishes his professional fee, he is in the general sense "fixing" his "price," but as long as he does not establish that fee in concert with competing pharmacists, his "price fixing" activity is lawful. Similarly, when a third party payment program unilaterally establishes the amount it is willing to offer to pharmacists as a professional fee for their participation in the program, there is no unlawful price fixing. This would be true even though that price is provided to an organization which processes claims on behalf of the third party payment program sponsor and the offer is transmitted by that organization to the pharmacist. The number of programs serviced by the administrator is, by itself, not legally relevant to allegations of price fixing.

If, on the other hand, one third party payment program were to be establishing its contract offer in concert with other third party payment programs or with an independent claims processing organization, there would likely be a price fixing violation of Section 1 of the Sherman Act.

Despite the fact that the Association frequently hears unlawful price fixing allegations based on "take it or leave it" aspects of third party payment contract offers, the Association, in my experience, has yet to be provided with an *evidence* that unlawful activity has occurred.

This is another instance in which the use of labels is nonproductive and frequently leads pharmacists to mistaken legal conclusions. I am sure that this type of complaint to the Association will continue, and I expect that it will simply have to make the effort to explain the appropriate application of the Sherman Act to third party payment program situations.

Peter P. Lamy Resigns Hospital Post



Dr. Peter P. Lamy who had served as Institutional Editor for The Maryland Pharmacist for several years, has resigned as Chairman of the Department of Institutional Pharmacy Programs at the University of Maryland Hospital. Under his direction, the pharmacy at University Hospital has been converted to a complete unit does system. Also introduced were intravenous systems, pediatric packaging, a hospital formulary, a pharmacy residency program, and a reclassification of pharmacy personnel.

Dr. Lamy will maintain his position as Director of Institutional Pharmacy Programs at the School of Pharmacy while expanding the department to include the area of geriatrics.

Leonard DeMino Appointed Assistant Vice President

Leonard J. DeMino, of Wheaton, a member of the Maryland Board of Pharmacy, and the Maryland Pharmaceutical Association Board of Trustees, has been appointed Assistant Vice President for Professional Services for the Peoples Drug Store Division. Mr. DeMino's association with Peoples Drug Stores began in 1956 when he was employed as a clerk. Since that time he has worked as a pharmacist, assistant manager and manager. In 1972 he was named Director of Professional Services, a position he held until his current appointment.

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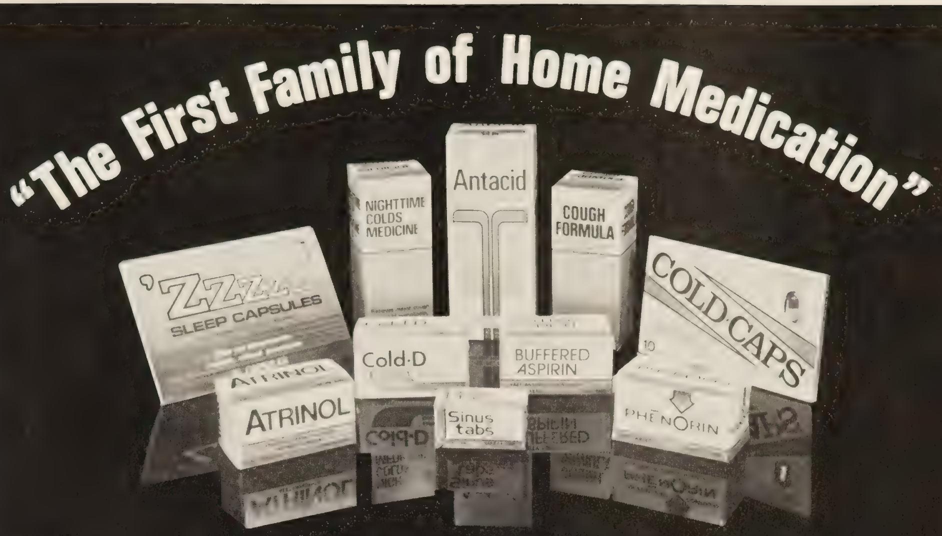

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Paul Burkhart Appointed Director of Pharmacy Services

Paul Burkhart has been appointed director of the Department of Pharmacy Services at the University of Maryland Hospital. This department is responsible for all inpatient and ambulatory pharmacy services which include a total unit-dose drug distribution system, an intravenous admixture program, a drug information center and specialized dosage development. In addition, pharmacy services is a training site for pharmacy technicians, undergraduate and graduate students studying institutional pharmacy.

Concurrent with his administrative responsibilities, Mr. Burkhart directs the hospital's pharmacy residency program and is a clinical assistant professor at the University of Maryland School of Pharmacy.

Mr. Burkhart has been associated with the hospital for eight years, most recently as associate director of the department. During his tenure, he has been instrumental in developing model patient teaching programs and a satellite pharmacy system.

Before coming to the University of Maryland Hospital, the new director worked in community and industrial pharmacy and was a member of the pharmacy staffs of several local hospitals.

Mr. Burkhart is a native Baltimorean who holds the B.S. degree and the M.S. degree in hospital pharmacy from the University of Maryland.

Active in state and national pharmacy organizations, Mr. Burkhart is currently a trustee of the Maryland Pharmaceutical Association and a member of the Council on Education and Manpower, American Society of Hospital Pharmacists. He is a past president and former chairman of the board of the Maryland Society of Hospital Pharmacists.

Mr. Burkhart has published extensively on the subject of patient education. His research has been in the areas of audiovisual support for patient education, and the planning and design of centralized and decentralized unit dose pharmacies.

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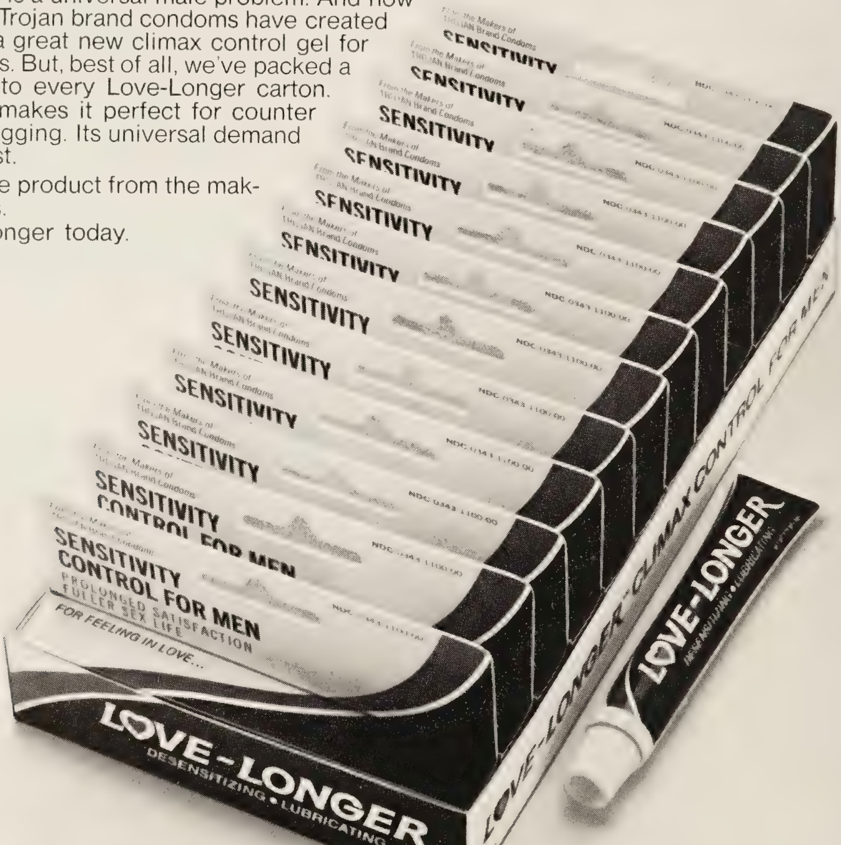
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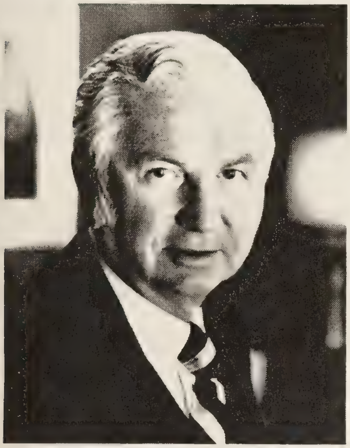

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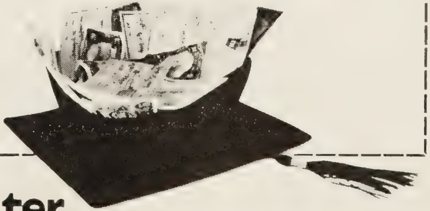

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Reported Cases of Gonorrhea Show Smallest Increase in 14 Years

In calendar year 1976 (52 weeks ending January 1, 1977), reported cases of gonorrhea increased by less than one-half of 1%, while reported cases of primary and secondary syphilis declined by 7.4% compared with cases reported during 1975 (provisional data Morbidity And Mortality Weekly Report [52]). Projections from 11 months of data on reported early syphilis cases (primary, secondary, and early latent cases) indicate a decline of 4.1% for 1976)

Since 1962, reported cases of gonorrhea have increased annually by at least 10.0%, and since 1968, early syphilis cases have increased by at least 4.7% (Figures 1 and 2). The alteration of trends in 1976 is believed to reflect the impact of control efforts which were intensified in 1972 when the federal government committed itself to a national gonorrhea control program and sharply increased its level of support to state and local health departments.

The introduction of penicillinase-producing strains of *Neisseria gonorrhoeae* into the United States during 1976 (MMWR 25[33, 38]) is expected to make it more difficult to control these diseases during 1977 than it was during 1976.

Reported by the Venereal Disease Control Division, Bureau of State Services, CDC.

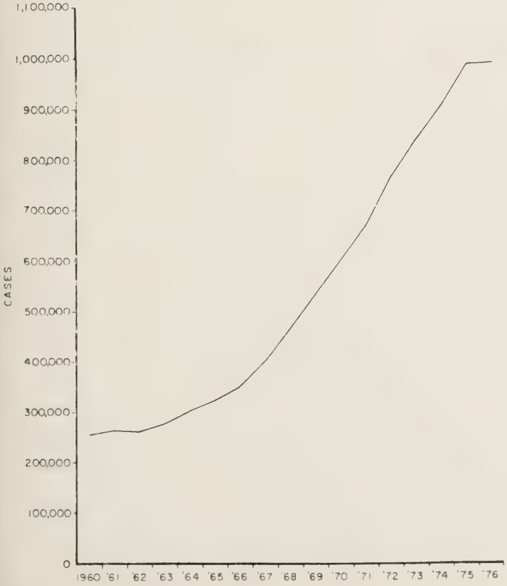
FIGURE 1. Gonorrhea, United States, 1960-1976

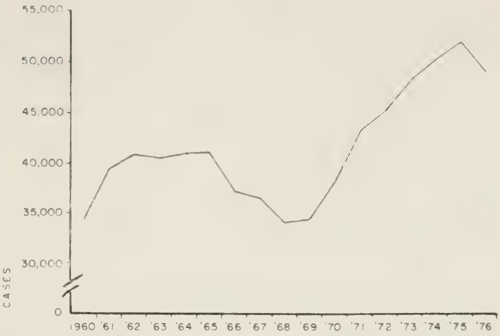
FIGURE 2. Total early syphilis, United States, 1960-1976

To Spouses of Pharmacists — A Special Message

I'm a member of APhA Auxiliary for the same reasons that I'm a member of Leon County Auxiliary and Florida Pharmaceutical Association Auxiliary. My husband is a pharmacist dedicated to his profession and I am interested in him and the profession he serves. Now I could just limit my membership to the local auxiliary — they do a lot of wonderful things like awards to pharmacy students, poison prevention programs, community service projects, etc., etc. But, that's just what it would be — limited.

It would be the same as limiting my voting to city and county races and not bothering with the state and national races. Each is dependent on the other and what you do in the community does make a difference nationally and vice versa. All are made stronger (or weaker) by the cooperation (or lack of it) by individuals. So it is with the work of the auxiliaries.

The sharing of ideas may hasten the solution to a problem or lend new insight to a community problem. Take the Little Jill program for example. It got its start in a local group, spread to several states, then national. Hopefully, through concerted efforts it will soon be made available to all states through a pooling of ideas.

I have learned through each phase of auxiliary work, and I've met a whole bunch of nice people in the process. Hopefully, I have made a contribution with some of my ideas.

This year I'm serving as membership chairman of the APhA Auxiliary. I hope that I've convinced you that joining the Auxiliary is worthwhile. However, it's your spouse I'd like to convince so won't you please take this Journal home to her and tell her to complete the following application and send with a check in the correct amount to Mrs. Hinton F. Bevis, 520 Truett Drive, Tallahassee, Florida, 32303.

Betty L. Bevis
Second Vice President
APhA Auxiliary

Application forms for APhA Auxiliary and Ladies Auxiliary to the Maryland Pharmaceutical Association are found on page 30.

obituaries

NORMAN LEVIN

Norman Levin, 49, owner of Leeds Pharmacy, died January 16, 1977. Mr. Levin was active in both Maryland and Baltimore Pharmaceutical Associations. He is survived by his wife Rhoda, his father Samuel, and his mother Beatrice, his son Charles Alan, and his daughter Bonnie who attends the University of Maryland School of Pharmacy.

A scholarship fund has been established in the name of Norman Levin, c/o University of Maryland School of Pharmacy, 636 W. Lombard Street, Baltimore, Maryland 21201.

Eli Lilly

Eli Lilly, honorary chairman of the Board of Directors of Eli Lilly and Company, the pharmaceutical firm founded by his grandfather a century ago, died January 24, 1977 in Indianapolis. He was 91.

Richard D. Wood, Lilly board chairman, said: "Mr. Lilly was an enormously effective business leader who had a profound impact on the course of this company. He was associated with it for more than 80 years. His life set standards of excellence, integrity, and compassion that will remain inspirational to all who knew him. Only rarely do uncommon talents and noble instincts blend with modesty and good humor to create a man like Eli Lilly."

More than any other person, Mr. Lilly was instrumental in transforming Eli Lilly and Company into a world enterprise making significant contributions to medicine and agriculture. He played a key role in many of the events that shaped modern drug therapy. These included the development of insulin for diabetes and liver extract for pernicious anemia in the 1920s, barbiturates in the 1920s and 1930s, the early production of penicillins and antibiotics in the 1940s, Salk polio vaccine in the 1950s, and significant new agricultural compounds for weed control and animal health in the 1960s and 1970s.

Mr. Lilly was born April 1, 1885, in Indianapolis, the elder son of Josiah K. Lilly, Sr., and the former Lilly Ridgley. He was the namesake of Colonel Eli Lilly, who founded the company nine years earlier.

He became a board member in 1907, the same year he joined the firm. He was instrumental in introducing modern industrial practices, including many work incentive programs for employees, the blueprinting of manufacturing formulas and the installation of straight-line production methods. He became superintendent of the manufacturing division in 1909 and general superintendent in 1915. Five years later he became vice-president, a position he held until succeeding his father as president in 1932. In 1948 Mr. Lilly became chairman, a position he held until 1961, when his brother, J.K. Lilly, Jr., was elected chairman. After the death of his brother in 1966, Mr. Lilly again became chairman. He returned to the position of honorary chairman in 1969 when the late Eugene N. Beesley was elected chairman of the board.

In 1936 he took his first major step into philanthropy by jointly donating, with his father, the Remington Memorial Laboratory to their alma mater.

In the following year, Lilly Endowment, Inc., was founded by the Lilly family, acting upon a proposal by Eli Lilly. The foundation, one of the largest in the world, has made grants of more than $300 million since its inception.

Mr. Lilly received 13 honorary degrees, the first of which came in 1935, when he was named a Master of Pharmacy by the Philadelphia College of Pharmacy and Science. In addition, DePauw University proclaimed him an honorary member of Phi Beta Kappa, scholastic honor society in 1939. The Republic of China honored him in 1942 for donations of medicines, and Norway presented him its St. Olav's Medallion in 1948. In 1958 the American Pharmaceutical Association gave him the Remington Honor Medal, which his father had received in 1942.

MPhA/MPhA Auxiliary

(continued from page 29)

Application For Membership
Auxiliary to the American Pharmaceutical Association

Approving of its objectives and agreeing to comply with its bylaws, I hereby apply for membership in The Auxiliary to the American Pharmaceutical Association.

NAME (Mrs.) (Miss) (Ms.) (Mr.) ____________________
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Signature ____________________

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Ladies Auxiliary to the Maryland Pharmaceutical Association

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Spouse's Name ____________________

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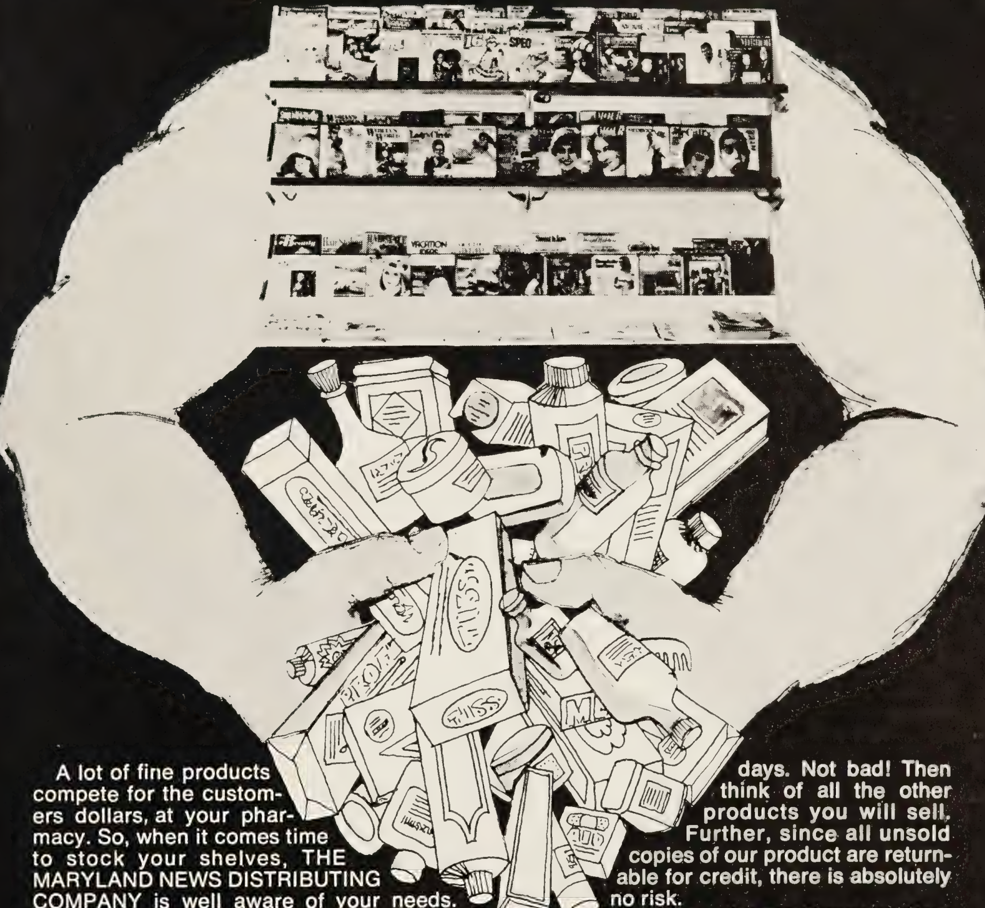

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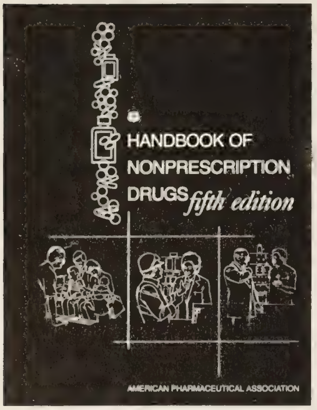

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4 **The Handbook features special "Questions To Ask The Patient" checklists for each chapter.** At a glance, they remind you of the questions you can use to establish an immediate, relevant, and professional relationship with your patients.

5 **The Handbook contains more than 70 pages of text tables, figures, illustrations and anatomical drawings.** The *Handbook* is the most generously illustrated book ever published by APhA, designed to furnish you with important supplemental information and quantitative data.

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Inspection of Pharmacies — How About Common Sense?

An Editorial

Compliance Obstacles to the Insulin Dependent Diabetic

Michael F. Powell and Peter P. Lamy

Multiphasic Testing

Nicholas Zenker

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MARCH 1977 VOL. 53 NO. 3

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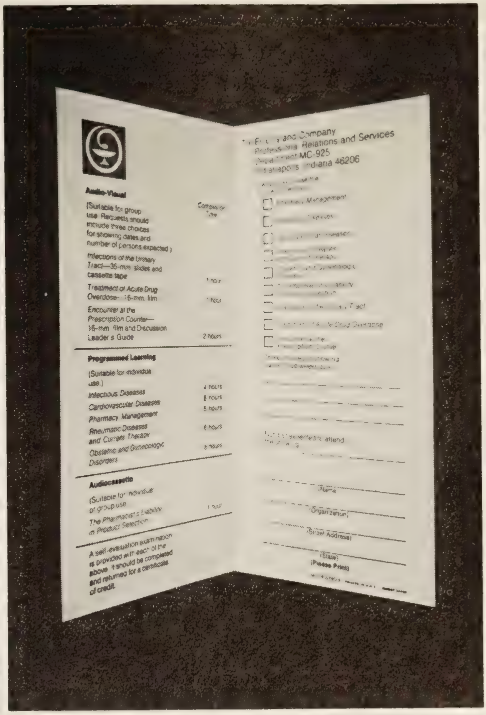
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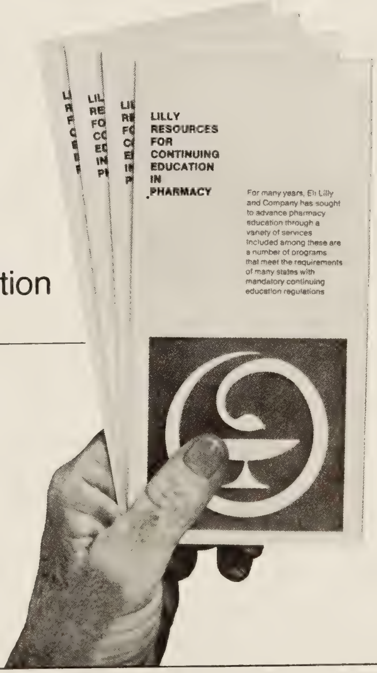
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Chronology of Presidents, Deans and Faculty Maryland College of Pharmacy and University of Maryland School of Pharmacy

by B.F. Allen, Ph.D.*

Maryland College of Pharmacy

Presidents

1840-42	Thomas G. Mackenzie
1842-44	Benjamin Rush Roberts
1844-71	George W. Andrews
1871-72	J. Brown Baxley
1872-73	J. Faris Moore (1847)
1873-75	John F. Hancock (1860)
1875-88	Joseph Roberts
1888-90	Edwin Eareckson
1890-91	William S. Thompson (1842)
1891-97	Louis Dohme (1857)
1897-1906	Charles E. Dohme (1862)
1906-07	Henry A. Elliott
1907-08	Charles H. Ware (1886)

Dean of Faculty

1896-1904	Charles Caspari, Jr. (1869)

(Figure in parentheses following name indicates year of graduation from Maryland College of Pharmacy).

University of Maryland Department of Pharmacy

(After merger with the University of Maryland in 1904)

Deans of Faculty

1904-17	Charles Caspari, Jr.*
1917-18	Daniel Base
1918-20	E.F. Kelly (1902)

*DIED IN OFFICE

(Figure in parentheses following name indicates year of graduation from Maryland College of Pharmacy).

Maryland College of Pharmacy

FACULTY

1841-43 Lectures in materia media, pharmacy and chemistry were delivered by the following seven members of the newly incorporated college (no professors then having been elected): Henry B. Atkinson, William H. Balderson, Robert H. Coleman, Israel J. Grahame, Thomas G. Mackenzie, Benjamin Rush Roberts, and David Stewart. The following were also members of the college and gave occasional lectures in the absence of the regulars: George W. Andrews, T.E. Brennan. John Hill, R.P. Littlefield, W.S. Love, John J. Myer, E. Raymond, William Smith Reese, James W. Scott, and Charles Wiseman.

1844-46 DAVID STEWART, professor of theory and practice of pharmacy; M.D., University of Maryland (1844).

WILLIAM E.A. AIKIN, lecturer on chemistry; M.D., Vermont Academy of Medicine; LL.D., Georgetown University (1843).

WILLIAM S. REESE, lecturer on materia medica.

1847-55 The college suspended all lectures during this period.

1856-58 CHARLES FRICK, professor of materia medica; M.D., University of Maryland (1845).

1856-60 ISRAEL J. GRAHAME, professor of practical pharmacy.

1856-61 LEWIS H. STEINER, professor of chemistry, and again from 1864-1865; MD., University of Pennsylvania (1849).

1858-63 FRANCIS DONALDSON, professor of materia medica; M.D., University of Maryland (1846)

1860-61 L. PHILLIPS, professor of practical pharmacy.

1861-64 ALFRED M. MAYER, professor of chemistry.

1861-88 J. FARIS MOORE, professor of practical pharmacy (1861-70), professor of pharmacy (1870-79), professor of botany and materia medica (1879-88); Ph.G., Pharmacy (1847); M.D., Jefferson Medical College, Philadelphia (1849); Phar. D., Maryland College of Pharmacy (1870).

1863-66 JOHN R. WINSLOW, M.D., professor of materia medica.

1865-66 JOHN C. CARTER, professor of chemistry; M.D., University of Maryland (1858).

1866-68 THOMAS H. HELSBY, professor of chemistry; M.D., University of Maryland (1859).

1866-79 CLAUDE BAXLEY, professor of materia medica; M.D., University of Maryland (1860).

(Continued on page 30)

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* Dr. Allen is Associate Professor of Pharcy, University of Maryland School of Pharmacy

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editorial

Inspection of Pharmacies — How About Common Sense?

In the February issue of THE MARYLAND PHARMACIST we pointed out that public information "sunshine laws" now require public agencies to open their files to both the press and the citizenry. The issue of Medicaid deficiencies was the subject. In this context we must also alert all pharmacists to the area of enforcement of the pharmacy and drug laws.

The recently instituted inspection procedures and forms of the State Division of Drug Control are based upon the specific requirements of the Maryland Pharmacy Law and both the state and federal food, drug and cosmetic acts. It should be pointed out that all the drug inspectors are employed by the Division of Drug Control as the Board of Pharmacy has no professional or administrative staff of its own. The matters under the jurisdiction of the Board are reported by Drug Control for Board review and appropriate disposition.

The files including inspection forms, reports and correspondence of the Division of Drug Control are open to public scrutiny. Media coverage and publicity, therefore, about actual or alleged violations are largely beyond the control of the Department of Health and Mental Hygiene and its Environmental Health Administration in whose bureaucracy Drug Control falls. However, it seems that some of the comments and speculative thoughts of officials as quoted in the media were at the least unnecessary, often injudicious and open to misinterpretation and distortion. The fallout on the profession was unfair, permitting a smearing of the majority for allegations which were unjustified or based upon ignorance of a complex issue.

The Maryland Pharmaceutical Association has been the pioneer in seeking the enactment of laws regarding pharmacy and drugs to protect the public health and interest. We have opposed proposals that were inimical to these aims and to the profession in carrying out its responsibilities to the public. We urge compliance with the spirit and letter of the law. We work through legislative, political and due process actions to secure our objectives and remedy inequities in a lawful manner.

At the same time we expect to be accorded consideration by governmental agencies as health professionals possessing the special qualifications by virtue of long and arduous education and training and of examination and licensure by the state.

We understand the need for uniform, organized methods, procedures and forms, but do not appreciate "points" used like a demerit system and scores that lend themselves to invidious comparisons.

Above all, let reason prevail. To permit a pharmacy to be publicized in the media as having a low score may result in almost irreparable damage to a pharmacist and his pharmacy's standing with his clientele. His crime may be the omission of a few one-inch red "C's" that are supposed to be imprinted in the lower right hand corner of prescription orders for controlled dangerous substances. His crime may be the misfiling of a few of the thousands of prescriptions dispensed.

We assert that the occurence of a few technical violations that are not a threat to public health should be a matter to be settled on the spot by representatives of Drug Control and not become the basis of reports and newspaper articles. Such common sense procedures could be handled by a minimum of personnel and red tape to the satisfaction of all parties.

We believe that the implementation of a recommendation we made many months ago of a liaison committee from the Maryland Pharmaceutical Association to the Division of Drug Control would be constructive. Proposals concerning pharmacy practice and drug control could receive the benefit of the knowledge and experience of those involved. We have also offered MPhA cooperation providing opportunities for education and information through association meetings, seminars, publications and mailings.

We must, of course, remember that licensure by the state implies a trust — a confidence imposed on us — a privilege, not a right granted us to provide a vital service to the community. We as pharmacists must provide no basis for allegations of misconduct. We must do our part in rooting out the few in our ranks who violate the ethical and legal canons of our profession.

– Nathan I. Gruz

calendar

May 11 (Wednesday) — State — MPhA Seminar on laws and inspections, Dorchester General Hospital, Cambridge, 8:30 p.m.

May 15-19 — APhA Convention, New York City

May 26 (Thursday) — LAMPA Dinner at Rosecroft Race Track

June 2 (Thursday) — University of Maryland School of Pharmacy Alumni Banquet, Eudowood Gardens

June 17-19 — MSHP Seminar, Sheraton Hotel, Ocean City, Maryland

June 19-22 — MPhA Annual Convention, Carousel Hotel, Ocean City, Maryland

October — Advance notice; MPhA trip to Rome.

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A Preview of Community Pharmacy . . . 1976

A preliminary *Lilly Digest* report of 845 community pharmacy operations submitting 1976 data reflects a year marked by a rising cost of goods sold and by only a slight dollar gain in net profit. When the preliminary data are expressed as percentages of total sales and compared with 1975 *Lilly Digest* figures, they indicate that . . .

The cost of goods sold increased, and even though total expenses declined slightly, the net profit before taxes fell to a level of 3.6 percent of sales.

Total sales reached a new high of $311,752, an increase of $17,967 (6.1 percent) over 1975 sales. The growth rate was lower, however, than the average annual growth rate of 6.8 percent recorded over the past decade. Prescription sales continued to advance at a faster rate (6.9 percent) as opposed to other sales (5.4 percent). During 1976, prescription sales, as a *percentage of total sales*, rose to 49 percent (up from 48.6 percent in 1975). The continued growth in prescription revenue in relation to nonprescription sales again illustrates the importance of the prescription department to the average community pharmacy.

With the higher cost of goods sold (larger percentagewise than the growth in total sales), the gross margin dropped to 35.2 percent of sales. This represents the lowest level since 1958.

Total operating expenses increased by $5,191 (5.6 percent), but, as a percentage of sales, were slightly lower (31.6 percent). Employees' wages improved dollarwise but declined to 11.6 percent of sales. The average proprietor's salary was $501 (2.2 percent) higher in 1976, but total income (salary plus net profit, before taxes) was 11.0 percent as compared with 11.4 percent in 1975.

The inventory level rose in total dollars but was actually lower as a percentage of sales. The sales productivity of the prescription department went up slightly — to $8.29 per stock dollar (a gain of 0.6 percent) — whereas other merchandise produced $4.80 per dollar invested in inventory, the same as reported in 1975.

The total number of prescriptions dispensed was 27,300, a decrease of 272 prescriptions. This represents a 1 percent decrease in comparison with 1975 data. New prescriptions continued to achieve a larger share of the total number of prescriptions filled. During 1976, they accounted for 47.5 percent of all prescriptions dispensed, up from 47 percent in 1975. The average prescription charge went up 42 cents during 1976, from $5.18 to $5.60 — up 8.1 percent.

SUMMARY

The preliminary 1977 *Lilly Digest* report of the 1976 operating figures of 845 community pharmacies is compared with the 1976 *Lilly Digest* averages of 1,710 pharmacies and is summarized in the following table. The annual *Lilly Digest* will be completed and distributed in September, 1977.

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LILLY DIGEST PRELIMINARY REPORT -- 1977

verages per Pharmacy	1976 (845 Pharmacies)	1975 (1,710 Pharmacies)	Amount and (Percent of Change)
ales			
Prescription	$152,779-- 49.0%	$142,915-- 48.6%	+ $ 9,864-- 6.9%
Other	158,973-- 51.0%	150,870-- 51.4%	+ 8,103-- 5.4%
Total	$311,752-- 100.0%	$293,785-- 100.0%	+ $17,967-- 6.1%
ost of Goods Sold	$202,116-- 64.8%	$189,624-- 64.5%	+ $12,492-- 6.6%
ross Margin	$109,636-- 35.2%	$104,161-- 35.5%	+ $ 5,475-- 5.3%
xpenses			
Proprietor's or Manager's Salary	$ 22,970-- 7.4%	$ 22,469-- 7.6%	+ $ 501-- 2.2%
Employees' Wages	$ 36,089-- 11.6%	$ 34,471-- 11.7%	+ $ 1,618-- 4.7%
Rent	$ 7,970-- 2.6%	$ 7,248-- 2.5%	+ $ 722--10.0%
Miscellaneous Operating Costs	$ 31,322-- 10.0%	$ 28,972-- 9.9%	+ $ 2,350-- 8.1%
otal Expenses	$ 98,351-- 31.6%	$ 93,160-- 31.7%	+ $ 5,191-- 5.6%
et Profit (before taxes)	$ 11,285-- 3.6%	$ 11,001-- 3.8%	+ $ 284-- 2.6%
Total Income (Net Profit plus Proprietor's Salary, before taxes)	$ 34,255-- 11.0%	$ 33,470-- 11.4%	+ $ 785-- 2 4%
Value of Inventory at Cost and as a Percent of Sales			
Prescription	$ 18,427-- 12.1%	$ 17,342-- 12.1%	+ $ 1,085-- 6.3%
Other	$ 33,095-- 20.8%	$ 31,439-- 20.8%	+ $ 1,656-- 5.3%
Total	$ 51,522-- 16.5%	$ 48,781-- 16.6%	+ $ 2,741-- 5.6%
Annual Rate of Turnover of Inventory	4.0 times	4.0 times	no change
Number of Prescriptions Dispensed			
New	12,975-- 47.5%	12,947-- 47.0%	+ 28-- 0.2%
Renewed	14,325-- 52.5%	14,625-- 53.0%	- 300-- 2.0%
Total	27,300-- 100.0%	27,572-- 100.0%	- 272-- 1.0%
Average Prescription Charge	$ 5.60	$ 5.18	+ $ 0.42 -- 8.1%

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Nathan I. Gruz, Editor
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Compliance Obstacles to the Insulin Dependent Diabetic

by

Michael F. Powell, M.S.*

Peter P. Lamy, Ph.D., F.C.P.+

Introduction

Diabetes mellitus is a chronic disease which is rapidly increasing in importance as a major health problem. Since 1950, the number of diabetics in the United States has increased 300 percent while the general population has increased by only 50 percent (1). According to the National Commission on Diabetes, the number of diabetics in this country will double every fifteen years, at the current rate of increase (2). Diabetes is now the third leading cause of death by disease, ranking only behind heart disease and cancer. Diabetes has also been cited as the second leading cause of blindness in the United States (1).

Diabetes mellitus is largely a disease of middle age. Of the over four and one-half million estimated diabetics in this country, about 80 percent are 45 years of age or older (3). Women in this age group are affected twice as often as are men (4). Additionally, over 80 percent of newly diagnosed diabetics are significantly overweight (4).

For the most part the cause of diabetes are unknown. However, the pathogenesis of diabetes is probably attributable to some inheritable trait (5,6). It is estimated that 25 percent of the American population is now carrying the defective genetic material (6).

The Pathology of Diabetes Mellitus

Essentially, diabetes is a metabolic disorder in which the metabolism of carbohydrates is impaired and that of fats and proteins is enhanced due to a relative or an absolute deficiency of insulin secretion (3,4). Certain symptoms are characteristic of the diabetic state. These include frequent urination, excessive thirst, increased appetite, weight loss, visual disturbances and slow healing of cuts and scratches (3, 4-9). However, not all diabetic patients experience these symptoms. Some will have several while others will have no apparent symptoms.

There are two types of diabetes mellitus. Approximately 90 percent of all diabetics are afflicted with the late-onset, ketosis-resistant form of the disease (10). Current research indicates that late-onset diabetes is due to a malfunction of both insulin and glucagon binding at the hormonal receptor level (11). The juvenile-onset form of the disease is now thought to be related to a viral etiology (1).

Failure to control the diabetic state may lead to serious, acute manifestations of the disease, such as acidosis and coma. Acidosis results from accumulation of ketone bodies which are produced when the body catabolizes fats and proteins to produce energy because it can not utilize glucose (3).

Even when the symptoms of the disease are apparently controlled, many long-term complications may arise. These may manifest themselves as impaired coronary or cerebral circulation due to accelerated atherosclerosis. Thickening of the basement membrance of the microvasculature is responsible for impaired periphereal circulation which can lead to retinal damage, ulceration, poor wound healing and increased susceptibility of infections. Periphereal nerve dysfunction is also a common complication (3-8). However, until recently, there was little, if any, evidence that control of blood glucose levels did more than delay the onset of these complications.

Diabetic Therapy

Many investigators now believe that restoration of normoglycemia may halt and even reverse the progression of complications (12). The inability of injected insulin to prevent periods of hyperglycemia has led to the investigation of three new techniques for the restoration of normoglycemia, transplantation of a healthy pancreas,

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• Abstracted from a thesis submitted to the Graduate School, University of Maryland at Baltimore.

* Mr. Powell at the time of the study, was a graduate student, serving a residency at the University of Maryland Hospital, Department of Institutional Pharmacy Programs. Current Address, Assistant Director, Robert B. Green Memorial Hospital, 4502 Medical Drive, San Antonio, Texas 78284.

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transplantation if islets of Langerhans, and implantation of an artificial pancreas. Additionally, the role of glucagon in blood glucose homeostasis and ketone metabolism has received much attention, particularly in reference to the development of Ketoacidosis (13). However, reports are conflicting and much research is needed before conclusions may be reached regarding the role of glucagon in the pathogenesis of diabetes.

The primary methods now employed in the management of diabetes mellitus include dietary control, administration of insulin or oral hypoglycemic agents, and regulation of exercise (4, 6-9). After the physician chooses the appropriate combination of these modalities, successful management is largely dependent upon the patient. Control of diabetes thus becomes a function of how well the patient adjusts the normal daily routine to accommodate the necessary self-care activities (Table I) (14, 15).

TABLE I
THE MOST IMPORTANT SELF-CARE ACTIVITIES OF THE DIABETIC PATIENT

Activity	Purpose
Dietary Control	Regulation of caloric intake and weight control; delay of vascular complications.
Exercise Regulation	Avoidance of unnecessary swings in blood glucose levels due to irregular exercise.
Medication (Insulin or Oral Hypoglycemics)	Regulate blood glucose; prevent vascular, neurologic, renal, ocular complications.
Urine Testing	Monitor control of blood glucose; monitor effects of other diseases on control.
Foot Care	Prevention of injuries; detection of unnoticed injuries; avoid infections.
Oral Hygiene	Maintenance of the integrity of the gingiva; detection of abscesses.

The degree of control achieved depends mainly on the diabetic's understanding of the need for rotation of injection sites, the care of instruments, the correct methods of urine testing, and dietary control (6).

Obstacles to Diabetic Compliance

Interruptions in the diabetic patient's daily routine of dietary control, urine testing, personal hygiene, and medication administration can upset control (8). Dietary control is one of the more important measures the diabetic must follow (17,18). Regulation of the size and frequency of meals helps protect the patient from symptomatic hyperglycemia and hypoglycemia (16). Perhaps more importantly, control of caloric intake helps the diabetic to achieve and maintain ideal body weight (19). West (20) demonstrated that clinic diabetes is accompanied by the highest incidence of complications in populations whose diets promote obesity.

The diabetic patient using insulin must be concerned with the properties of insulin. Most commercially available insulin preparations are milky suspensions which are stable for long periods only if stored in the refrigerator (21). However, it has been noted that atrophy at the site of injection may be more common if cold insulin is injected (22). Before injection of the suspension, the patient should allow the insulin to warm to room temperature and then roll the vial gently between the palms of his hands. Shaking the vial could cause excessive foaming and prevent accurate measurement of the insulin dose (3).

The use of incorrect insulin syringes and improper techniques for filling the syringe can cause dosage errors. At present, insulin syringes are available with calibrations for use with U-40, U-80 and U-100 insulin. The American Diabetes Association has cited confusion due to the availability of these several types of insulin syringes as a major source of error in insulin dosages (23). The confusion may be especially profound when dual scale syringes for U-40 andU-80 insulin are used (12). Dead space volume, that is the volume of insulin contained in the hub of the syringe and the needle, has also been cited as a potential source of dosage error (22). Disposable syringes[a] manufactured by Sherwood Laboratories have been shown to deliver insulin volumes varying by as much as eight units. Diabetic patients should, therefore, be cautioned to be certain that they are using the correct insulin syringe and to avoid using insulin syringes from different sources.

Two types of syringes, the reusable, glass syringe and the disposable, plastic syringe, are available. The reusable, glass syringes must be kept sterile by storing the parts of the syringe in 70 percent ethyl or 91 percent isopropyl alcohol, and by boiling them at least once a week. Disposable plastic syringes should be discarded after one time use. Failure by the patient to observe these rules can lead to infections and hyperglycemia.

One of the more distressing problems related to insulin administration is the occurrence of changes in subcutaneous fat at the sites of injection (24). These changes, called lipodystrophy, may take the form of hypertrophy or atrophy. Tissue hypertrophy may lead to a kind of insulin resistance due to the avascular character of the subcutaneous fat tissue. Both hypertrophy and atrophy have been attributed to failure by the patient to rotate injection sites adequately (20). Moreover, some grades of 70 percent isopropyl alcohol used to clean injection sites contain potentially irritating impurities which can cause a local reaction (25).

In general, diabetic patients are more susceptible to bacterial and fungal, especially monilial, infestations than is the general public (12). Impaired periphereal circulation, especially in elderly diabetic patients, reduces the diabetic's resistance to infection (26). Also neuropathies experienced by these patients can produce insensitivity to pain. As a result, blisters or cuts can become infected before they are noticed, unless the patient examines the extremities, especially the feet, carefully everyday.

Urine testing for glucose is used by patients and physicians to monitor control of blood glucose levels. Several different urine tests, based on either copper reduction or glucose oxidase reactions, are available to diabetic patients. Copper reduction methods, such as Clinitest®, are not specific for glucose while those based on the glucose oxidase system are. However, Clinitest® is generally considered to be the method of choice for monitoring insulin therapy because glucose oxidase tests, such as Tes Tape® and Clinistix®, are quantitative only when the amount of glucose in the urine is less than 0.25 percent. Still, glucose oxidase methods are preferred for monitoring most cases of diabetes, especially

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the adult onset type, because of their simplicity, specifity, and ability to detect such minute amounts of sugar in the urine (3). Because the color changes for each urine test method are different, use of incorrect color charts may lead to errors in the interpretation of urine test results (27).

Compliance by the Diabetic Patient

Studies conducted among diabetic patients have shown that errors in the performance of self care activities are all too common (28-33). In one study, Watkins, *et al.* (31), reported that 58 of 115 insulin dependent diabetics committed dosage errors of two or more units. Only 23 percent of these patients tested their urine correctly and recorded the results, and less than 50 percent carried out acceptable foot care. Poor patient performance was also recorded in the care of insulin equipment and dietary control.

In another study, Williams, *et al.* (35), found that patients with more knowledge of diabetes tended to manage their self-care activities better than those with poor understanding of the disease. In an earlier study, Etzweiler, *et al.* (34), observed similar deficiencies in knowledge of the disease by diabetic children and their parents and in the performance of self-care activities. Quite often, diabetic patients do not consider themselves as patients at all. Davis, *et al.* (35), studied the attitudes of diabetic children attending a Florida diabetic camp towards the disease. The children displayed a definite lack of understanding of the disease. In fact, several of the children felt they would rather have diabetes than several far less serious conditions, such as acne, constipation, or obesity.

Summary

Diabetes mellitus is a chronic illness which is rapidly becoming of increasing concern in terms of morbidity and mortality. Diabetes mellitus is a genetically lined metabolic disorder in which there is an absolute or a relative deficiency of insulin secretion. Control of the acute symptoms and the long term complications is dependent upon how well blood glucose levels are controlled.

Current trends in diabetic therapy are based upon findings indicating that restoration of normoglycemia may halt and even reverse the progression of complications. Despite the emergence of several new techniques for the restoration of normoglycemia, the success of the primary methods employed in the management of diabetes mellitus depends largely upon how well the patient integrates a complex self-care regimen into his daily routine. Several obstacles exist which can interrupt the diabetic patient's daily routine of dietary control, urine testing, personal hygiene, and insulin administration. These interruptions in the performance of the daily routine of self-care activities can also upset diabetic control.

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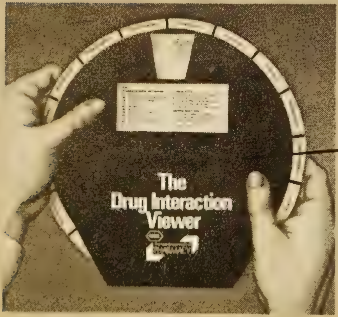
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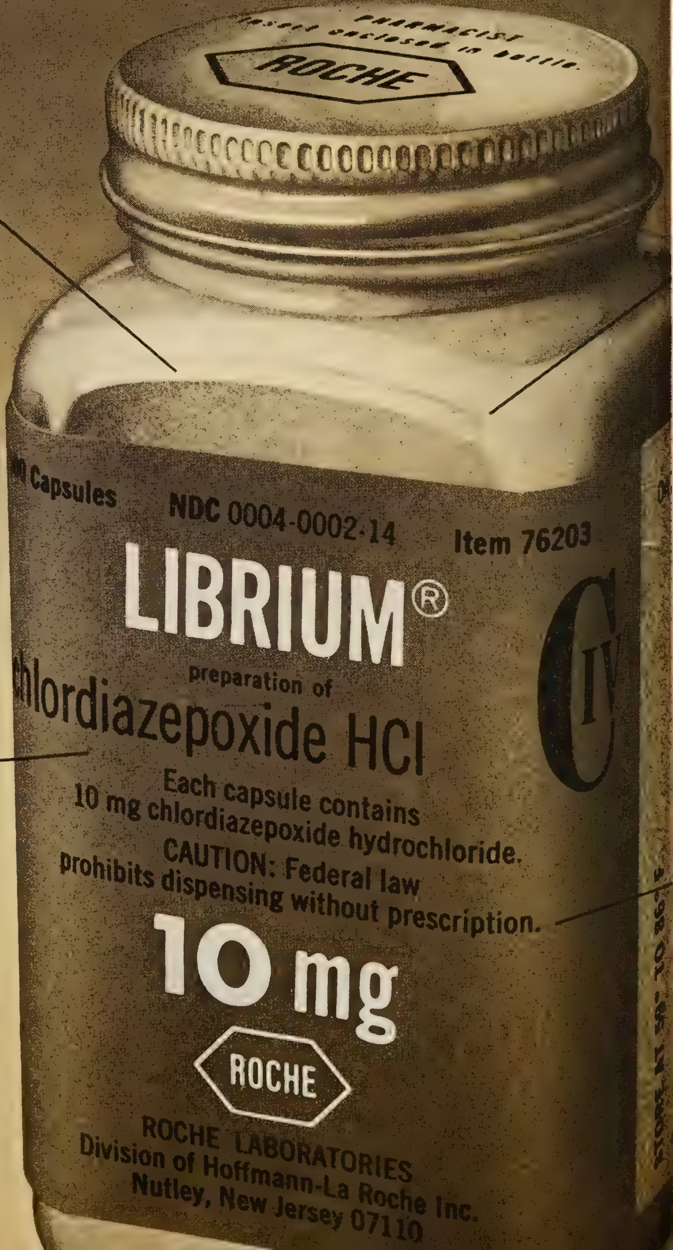
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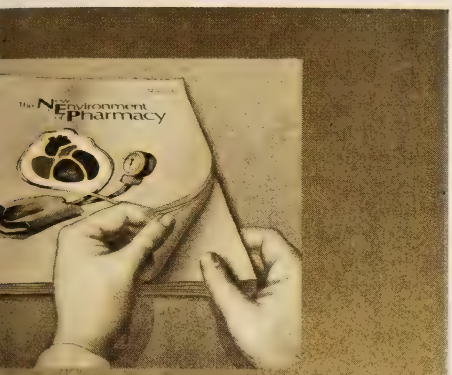

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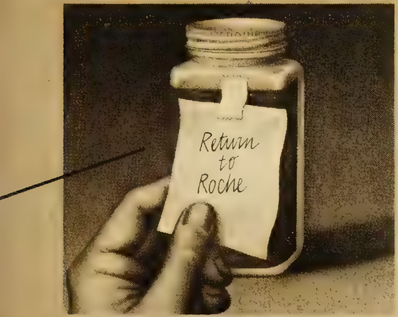

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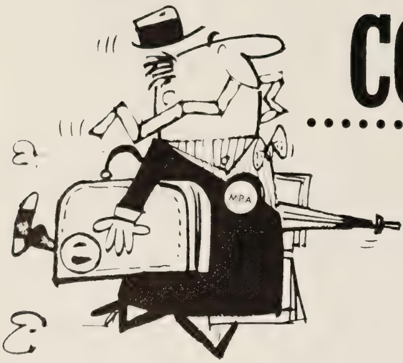

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MPhA ANNUAL CONVENTION AND FAMILY MINI-VACATION

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Follows MSHP Annual Seminar June 17-20 at Sheraton

PROGRAM HIGHLIGHTS

SUNDAY, June 19	-	Registration opens 12:00 Noon Tennis Tournament begins - Golf available Children's supervised programs daily
9:30 P.M.	-	*Welcome cocktail party and ice show*
MONDAY, June 20 9:00 A.M. to 1:00 P.M.	-	Opening General Session House of Delegates - First Session Officers' Reports Report of Board of Pharmacy
10:00 A.M.	-	*LAMPA - Brunch, Meeting and Fashion Show* TAMPA - Annual Meeting
1:00 P.M.	-	Tennis continues, Volley ball at beach
6:30 P.M.	-	*Crabfeast and chicken at Berlin Fire Hall* *TAMPA Program: Square Dance*
TUESDAY, June 21 9:00 A.M.	-	House of Delegates - Second Session Elections of Nominees to State Board of Pharmacy Nomination of Officers and Trustees for Mail Ballot
6:00 P.M.	-	*Cocktail Party*
7:00 P.M.	-	*Annual Banquet Speaker: C. Joseph Stetler, President, Pharmaceutical Manufacturers Association*
WEDNESDAY, June 22 9:00 A.M. to Noon	-	Continuing Education Sessions - Certificate of Attendance and C.E. Credits - Co-sponsored by APhA Academy of Pharmacy Practice. *Audio visual presentation: "The Pharmacist, The Pharmacy, and Professional Body Language".* Workshop with *Ronald L. Williams.*

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The Dent-Pharm Therapeutics Program

by

Richard M. Oksas, Pharm.D.*

Miriam Kamanitz, R.Ph.†

One of the newer concepts regarding the delivery of health services is that of the "health care team." This essentially involves integrating the professional expertise of various practitioners in providing comprehensive care to the patient. To foster such an idea requires early interdisciplinary training of students, enabling them to learn to communicate and recognize each other's capabilities.

Realizing this to be a fact, the University of Maryland Schools of Pharmacy and Dentistry began a cooperative teaching and service program in 1974. Later to be known as the "Dent-Pharm Therapeutics Program," the initial objectives were as follows:

a. Identify faculty to function as role models of each profession, who would also be available as clinical information sources to students.
b. Create an elective student exchange program between the two schools to foster better understanding between professions.
c. Establishment of a distribution pharmacy at the University's Dental Clinic for purposes of patient convenience as well as a drug information center.

To date all of these objectives have been accomplished.

In relation to the first goal, Dr. Raymond Garrison, D.D.S., and Dr. Richard Oksas, Pharm.D., were hired as coordinators for each of their respective fields. They, along with other faculty members from both schools, provide an introductory lecture series to all students of pharmacy and dentistry about their professions. They are also available for consultation when patient care is being rendered involving the dental use of drugs. It is hoped that continuing education presentations will be offered in the near future to familiarize community practitioners with basic information in this regard.

Further reinforcement of this concept is afforded by the student electives mentioned previously. A special study rotation of the Professional Experience Program in dentistry is available to senior pharmacy students. Two students spend one month at the dental school to learn about dental service and dental drug utilization. This experience is broken down into four component parts:

1. A *preparatory phase* with seminars given in dental anatomy, pathology, treatment and drug use. Also, selection of dental OTC products and the pharmacists role in patient education of their proper use is discussed. This orientation is given before student deployment.
2. A second *clinical phase* of 10 days at the dental school. During this time the pharmacy student takes drug profiles (histories) of dental patients and observes dental care being given at the school's specialty clinics. Areas visited include Oral Diagnosis, Special (Handicapped) Patient Clinic, Oral Surgery, Periodontics, Pedodontics, and Endodontics with drug use defined in each.
3. Next comes the *practice-application phase* where the student is assigned to a community pharmacy to apply the knowledge he has acquired about preventive dentistry and dental products. Additionally he/she spends time in the school's Dental Pharmacy to learn communication skills in patient education.
4. The rotation is completed with a one week directed *research phase* where the student studies a topic of personal interest in dental pharmacology.

Dental students enroll in a similar elective rotation through pharmacy service areas. During this experience 10 dental students spend 2 hours per week for 5 consecutive weeks visiting faculty preceptors in community pharmacy, hospital pharmacy, clinical pharmacy, nuclear pharmacy and the poison information center. They are encouraged to ask the pharmacists involved how to better utilize the available pharmaceutical services.

The final objective of the Dent-Pharm Program was to establish a service component in the form of a dispensing pharmacy. This venture was necessitated by the fact that many of the school's patients either did not have their prescriptions filled or failed to use dental products properly. With the existence of a dental pharmacy, the dental school hoped to provide more comprehensive care by having available commonly used drugs and a pharmacist to help instruct patients. Additional benefits included centralization of the school's drug supply and a learning environment for both dental and pharmacy students.

The Dental Pharmacy became functional in the spring of 1977 and is located on the first (main clinic) floor of the Dental School, adjacent to the Oral Surgery and Oral Diagnosis clinics. It is open year round corresponding to the hours of the clinic operation. Although it is licensed as a community pharmacy, several services make it unique from traditional modes of practice. For example the policies regarding drugs selected for use within the dental school is established by a joint faculty committee. In a similar fashion the pharmacy stocks only ADA approved OTC oral hygiene products. Finally, the pharmacy has the capability of providing unit dose injectable drugs to be used at the time of dental treatment. Other policies mimic normal pharmacy practice in order that dental students and faculty alike can learn what to expect from pharmacy service in the communities.

---

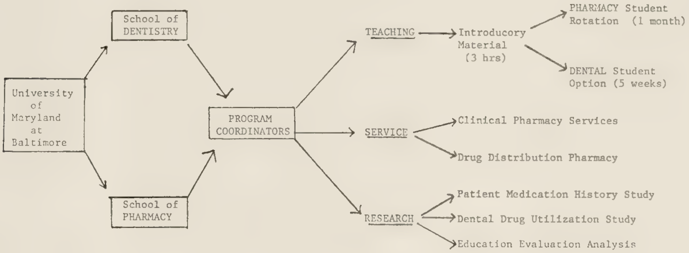
*Dr. Oksas is Dent-Pharm Therapeutics Program Coordinator at the Schools of Dentistry and Pharmacy

†Ms. Kamanitz is Dental Pharmacist at the new pharmacy in the Dental School

With the addition of the Dental Pharmacy, the Dent-Pharm Therapeutics Program hopes to create a dental image of a pharmacist being both a provider of drugs and a source of drug information. Simultaneously, an effort has been made to properly train pharmacy students to assist dentists and their patients.

In conclusion, the outcome of more interdisciplinary cooperation will be fully realized with the program's presentation of continuing education courses to both practitioner groups.

COMPONENTS OF THE DENT-PHARM THERAPEUTICS PROGRAM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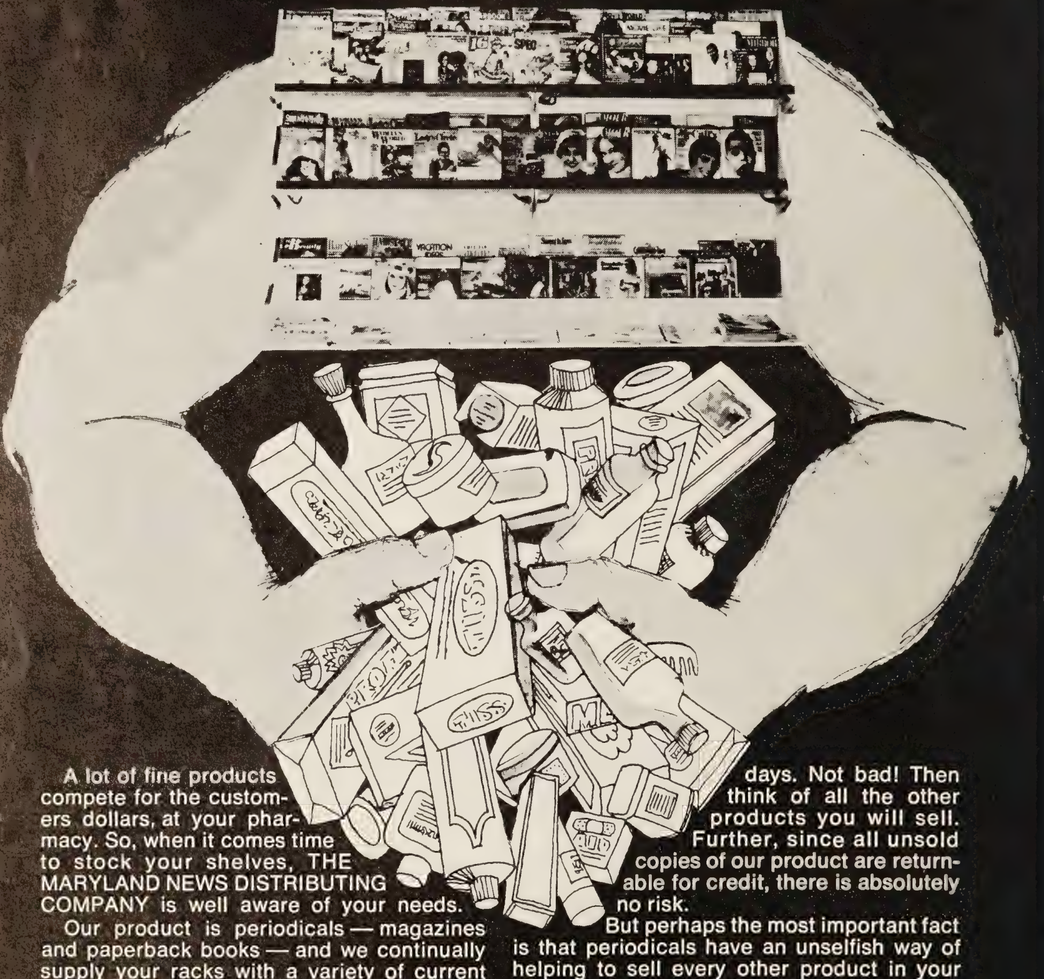

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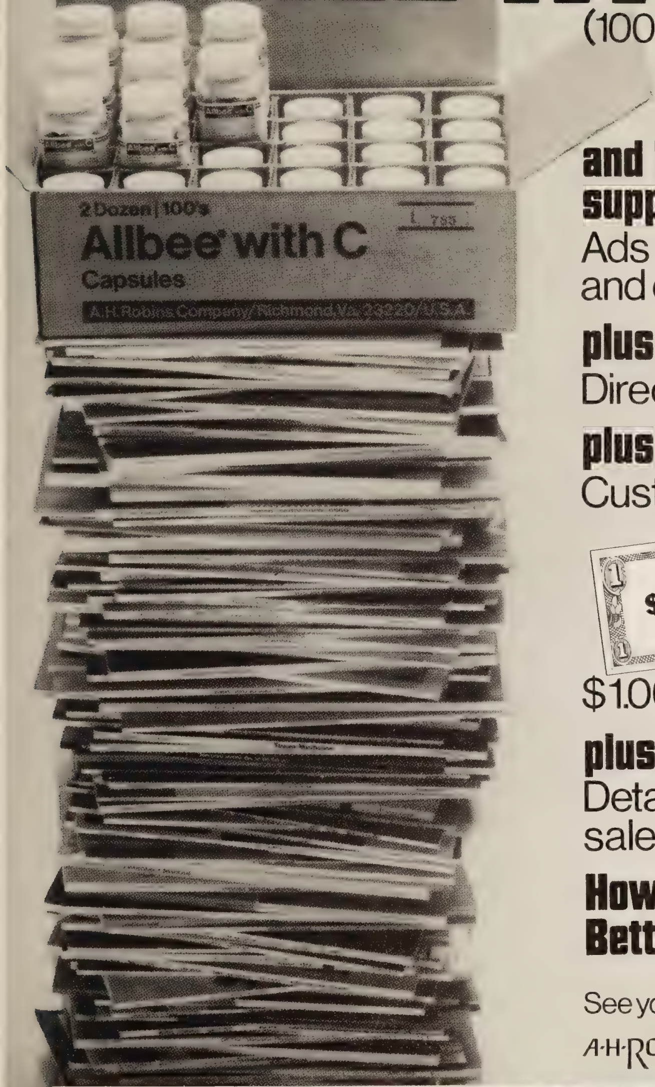
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(APRIL 1—MAY 27, 1977)

Multiphasic Testing

by Nicholas Zenker, Ph.D.*

In the presentation of a patient at rounds, clinical laboratory values are viewed only with the context of other diagnostic information: the lengthy description of the patient's signs and symptoms precedes the listing of laboratory test values. The limitations of laboratory tests, and especially those of clinical chemistry have included in the past a lack of sensitive or specific methods, cost per unit, differences in the day-to-day or person-to-person technical performance of laboratory personnel and lack of statistical sophistication in the establishment of "normal ranges."

In the near-past, the gradual development of radioimmunoassay (RIA) methods has permitted the evolution of sensitive and specific micromethods while the introduction in clinical laboratories of automated analytical systems (Auto Analyzer, CentrifiChem., etc.) has permitted a drastic reduction in the cost per test and eliminated the impact of individual variations in analytical technique. Also, recently, automated instruments which were used at first only for frequently requested laboratory tests such as blood glucose or Blood Urea Nitrogen have gradually been employed to perform more sophisticated tests/have eventually evolved the technology necessary for multiphasic testing.

Multiphasic testing is the determination, by automated equipment, of the concentration of several key metabolic indicators so as to provide a meaningful biochemical profile of the patient. The SMA 6/60 which provides the simultaneous determination of six basic tests points to the most frequently used tests of clinical laboratories: Glucose and Blood Urea Nitrogen, Sodium and Potassium, total Carbon Dioxide and Chloride. In the SMA 6/60 Chart (Fig 1A), the units of concentration, either in milliequivalents per liter or in milligrams per 1000 ml of blood are listed on a vertical scale with a special hatched space denoting the normal range (Fig 1A). Although some recurring general relations (such as carbon dioxide increase secondary to hypokalemia) are assumed, the reading of multiphasic charts is more often than not a straight forward application of biochemical principles: this is summarized by Table I and illustrated by two examples.

In the first example (Fig 1B), the elevated glucose level points to an excess of hormones or more probably to a lack of insulin (Table I). Under normal conditions, the serum cations are balanced by serum anions. This balance is suitably expressed as the difference sodium minus bicarbonate (approximated by total carbon dioxide) and chloride, is normally equal to 10 + 5 and is referred to as the anion gap:

$$\text{Anion GAP} = [Na_{+}] - [CO_2] - [Cl_{-}]$$

An increase in the anion gap indicates most frequently an increase in lactate or in the acidic ketone bodies and is an index suggesting metabolic acidosis. Thus in Fig 1B, the anion gap of 30 together with the elevated blood glucose strongly suggests diabetic ketoacidosis. The slightly elevated BUN indicates a slight kidney damage which is certainly consistent with the picture of ketoacidosis.

In the second example (Fig 1C) the low blood glucose indicates an excess of insulin or a decrease in glucocorticoid levels. Low levels of sodium and chloride point to low salt retention and hence to a deficiency of mineralocorticoids. The overall picture then suggests an adrenocortical deficiency, such as seen in Addison's disease.

A more complete set of tests would provide indices of nitrogen balance (protein), of hepatic function (bilirubin, albumin, alkaline phosphatase), of cardiac function (Enzymes such as SGOT), and indices of bone activity (calcium, phosphate, alkaline phosphatase). The metabolic pattern afforded by such a battery of tests is much more useful than the single number given by one: an elevated LDH is a nonspecific indication, but elevation of LDH, bilirubin, and alkaline phsophatase with a low-normal or low albumin clearly point to hepatic involvement.

There are many esoteric and specialized tests performed in clinical laboratories, but to understand tests commonly performed only a minimal background in physiological chemistry is required. Such a background would appear within reach of most pharmacy practitioners.

Table I
Background for Six Common Laboratory Tests
Selected Causes for Deviations

Metabolic Test	Elevation in	Decrease in
Glucose	Lack of insulin Excess of other hormones (Adrenal Steroids, Thyroid Hormones)	Excess of insulin Lack of adrenal steroids
Blood Urea Nitrogen	Renal Disease Cardiac Impairment	Hepatic Impairment or Damage
NA+	Excess adrenal steroids (Cushing's syndrome)	Lack of adrenal steroids (Addison's disease)
K+	Lack of adrenal steroids Kidney Impairment Acidosis	(See elevated Na+)
CO_2 ✓ (mostly HCO_3)	Metabolic alkalosis Excess adrenal steroids	Metabolic acidosis (Starvation, Diabetes)
Chloride	Metabolic acidosis	Metabolic alkalosis Renal disease

Figure 1. The SMA 6/60 Chart

A. A SMA 6/60 chart with scales for chloride, carbon dioxide (total carbon dioxide, mostly bicarbonate), potassium, sodium, Blood Urea Nitrogen and glucose. The normal range is indicated by slash marks.

B. Profile Encountered in Ketoacidosis
The main points of this profile are the greatly elevated blood glucose pointing to a diabetic state and the low carbon dioxide which, in the presence of normal sodium and chloride, indicates an increased anion gap and, therefore, acidosis.

C. Profile in Addison's Disease
In Addison's disease, there is a lack of adrenal steroids. The low blood glucose and the low sodium and chloride are consistent with decreased levels of glucocorticoids and mineralocorticoids.

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* Dr. Zenker is Professor and Chairman of the Department of Medicinal Chemistry, University of Maryland School of Pharmacy.

Fig. 1A

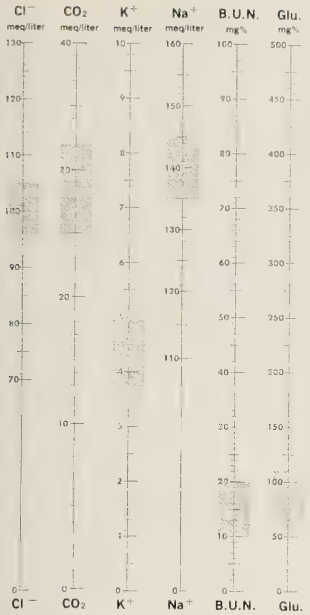


Fig. 1B

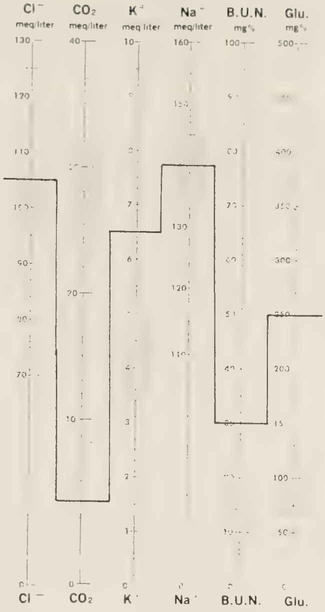
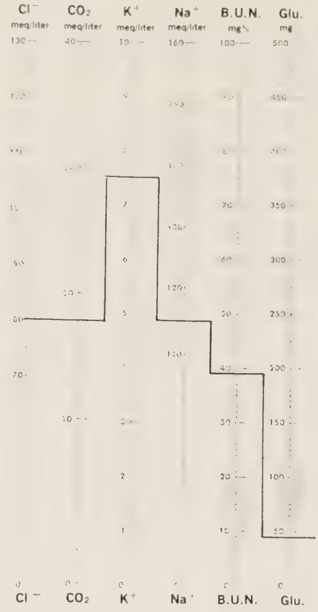


Fig. 1C



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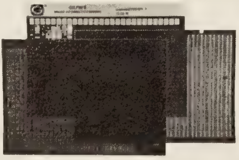

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A 1

"Robbery prevention costs less!"

by Thad L. Weber, Security Consultant, SK&F Laboratories

Robbery attacks against pharmacies can be very costly, involving loss of life, personal injury, loss of currency and drugs, and damage to property.

While the average amount taken during a robbery is less than $100.00, the loss in terms of mental trauma, employee turnover, permanent disability or death is immeasurable.

And in most instances robbery losses are not covered by insurance!

Prevention of robbery is not an absolute science since individuals desperate for money or drugs will risk apprehension and commit acts of violence without compassion. However, many criminals can be deterred from attacking if they are *convinced,* while "casing" your premises, that "escape" will be very difficult and that apprehension may follow even a successful escape.

To *deter* a robber from the attack you must convince him (or her) that physical escape from your premises may be delayed, and that police response may be timely enough to apprehend the attacker; OR, the criminal must be convinced that while escape is probable, *automatic* cameras or other means of identification will culminate in apprehension, prosecution and conviction.

An **impression** of security against robbery may be achieved by:

- signs
- physical delay barriers
- alarm devices

Signs, insignificant from a cost standpoint, may include:

- decals placed on the entry door and at the cash register "advertising" silent emergency signal alarm systems available for use.
- notices that the insurance company requires alarm devices, electric door locks, and/or surveillance cameras as a condition of insurance.
- notices that "exact change" is required to cover purchases after. . .p.m. or on Sundays and holidays. This approach should also include a statement to the effect that the personnel on duty do not possess the key or combination to the safe in which "proceeds" are stored.

Physical barriers which might delay escape or increase the time required to effect the robbery include:

- **Safes,** which are used as repositories for cash removed from cash registers when previously established cash register limits are reached (or immediately, during night hours) *providing* the aforementioned signs and procedures are in effect.
- **Double deadlocks** on secondary doors providing such locks are in compliance with local fire safety codes.
- **Electric locks** on customer entry doors which *may* actually be used during periods when a lone person or limited staff is on duty, and experience teaches us that robbery incidence is high.
- **Bullet-resistant enclosures** might also solve the problem of doing business while staffing with lone employees in high crime areas during hours when other businesses are closed.

Alarm signal devices are equally strong deterrents to robbery since the simple capability to "call for help" threatens the robber's escape.

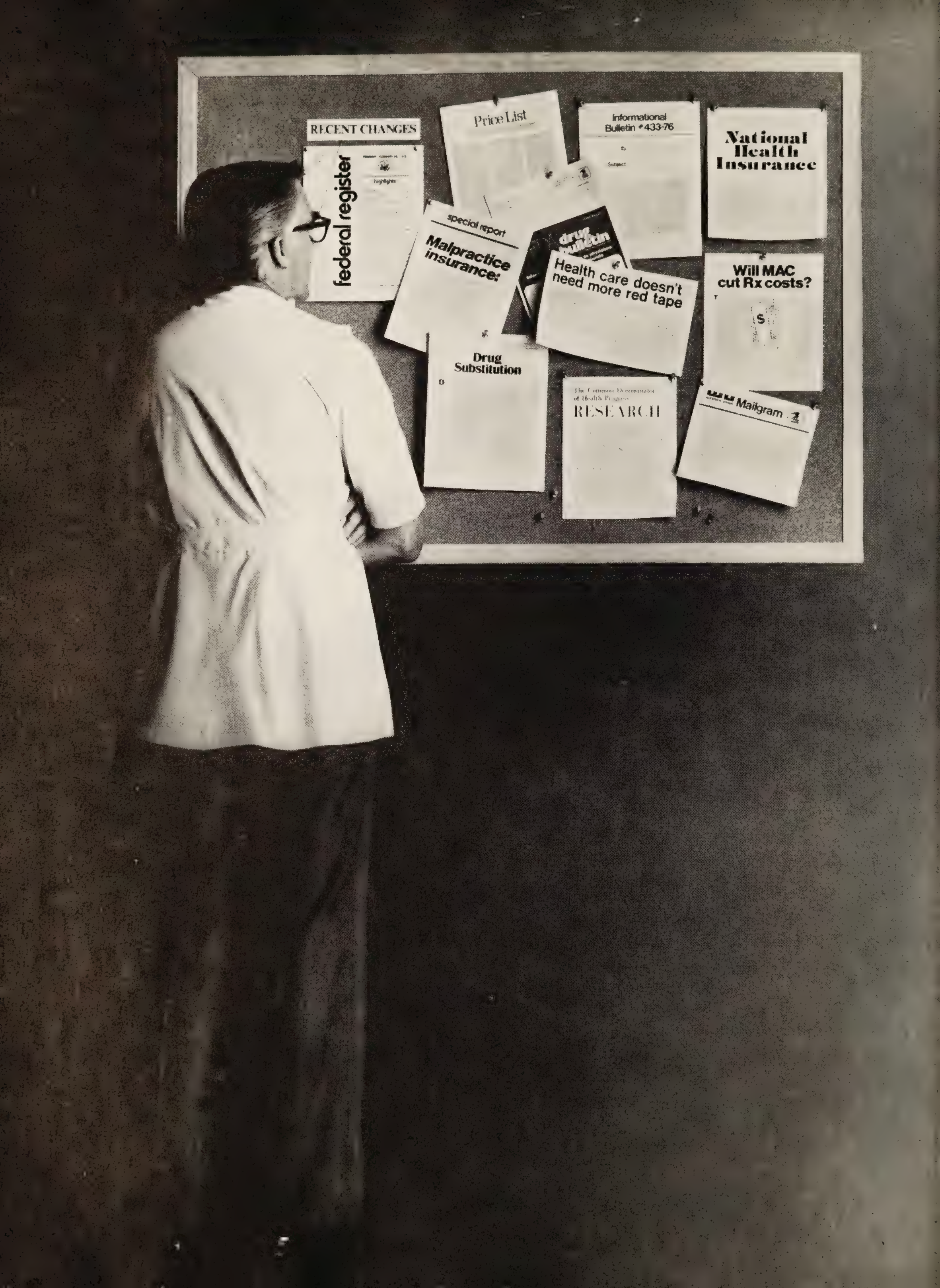
The principles which must accompany this deterrent are:

- Do not permit the location of all signal devices to be obvious.
- Advertise via signs the existence of the devices.
- Make sure they are silent in operation.
- Utilize wireless holdup signal devices and "advertise" the fact.
- Test the devices periodically to be sure they are operable.
- Include an "anti-ambush" type device in conjunction with the "opening" of a safe, drug cabinet or some other "point of robbery attack" container.

At first evaluation the cost of central station or some other form of emergency signal supervision may seem costly; however, this is not usually the case. Holdup or emergency signal devices may be efficiently remotely supervised when "duplexed" to (combined with) existing burglar alarm systems, by use of multiplex or McCulloh circuits, or when connected into dialers which utilize the pharmacy's existing telephone circuits.

Precautions related to emergency alarm systems:

1. If possible, install wireless signal receivers to permit activation from employee parking spaces, approaches to the premises, etc.
2. *Instruct* all employees never to activate a device once a holdup commences.
3. Consider alarm devices in toilets, closets, etc., where personnel may be imprisoned during a robbery.
4. Discuss holdup alarm procedures with local police.
5. Select signal devices to fit your environment (foot rails, money clips in cash registers, ambush devices in key-operated burglar alarm control units, etc.).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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND THE PATIENT.

Pharmacy today is in the spotlight, subjected to all kinds of scrutiny. Your actions are being monitored and judged, sometimes by unknown third parties.

The worry is that in the wake of this focus, your relationships with both doctors and patients will be weakened, without offsetting benefits. Consider three examples:

Drug substitution Until recently, state pharmacy laws, regulations, or professional custom have stipulated that non-generic prescriptions be filled with the precise products prescribed. But in the last five years, a number of these laws or regulations have been changed, permitting you, in varying degrees, to make the selection when a multi-source product is ordered.

These changes have been taking place against a background of growing evidence that purportedly-equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA has not enforced the same standards for hundreds of "follow-on" products that it has applied to original NDA approvals. This situation, it seems to us, is a compelling reason for product selection to rest on a sensible interchange between doctors and pharmacists—and not on legislative action.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant overall savings has been produced, nor is any likely, given the needs of pharmacy and the record of government in administering cost control programs.

MAC Maximum Allowable Cost, MAC for short, is a federal regulation intended to cut the government's drug bill by setting price ceilings for multi-source drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right, regardless of your economic or professional judgments. Pharmacists will have little to say about administration of the program, since government will have absolute authority to make its prices and fees stick. For other multi-source drugs on the MAC list, your reimbursement would be limited to a product price on a government "estimated acquisition cost" list and a state-established professional fee.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to patients: the cost of the research is more than ten times what it was, per product, in 1962, and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years or more now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present complex approval process contributes to needless delay of drug therapy. That's why the increased efficiency of the drug and device approval process is vital to all our futures.

We suggest you make your voice heard on these issues —among your colleagues and your representatives in state legislatures and in the U.S. Congress.

It could make a difference to patients and to the practice of your profession tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Chronology

(continued from p. 4)

1868-73 MOSES J. DeROSSET, professor of chemistry; M.D., University of the City of New York (1860).

1871-1904 WILLIAM SIMON, director of the chemical laboratory (1871-72), professor of analytical chemistry (1872-73), professor of chemistry and analytical chemistry (1873-75), professor of practical and analytical chemistry (1875-85), professor of general chemistry and analytical chemistry (1885-95), professor of chemistry and director of the chemical laboratory (1895-97), professor of chemistry (1897-1902), emeritus professor of chemistry (1902-04); Ph.D., University of Giesen, Germany (1869); M.D. Honorary, College of Physicians and Surgeons, Baltimore (1874).

1879-1904 CHARLES CASPARI, JR., professor of theory and practice of pharmacy and director of pharmaceutical manipulations (1883-95), professor of pharmacy and director of the pharmaceutical laboratory (1895-96), professor of pharmacy and director of the pharmaceutical laboratory, Dean of the faculty (1896-1900), professor of theoretical and applied pharmacy, Dean of the faculty (1896-1904), Ph.G., Maryland College of Pharmacy (1869).

1885-1904 DAVID M.R. CULBRETH, general quiz instructor (1885-95), professor of microscopy and practical botany (1886-87), professor of botany, materia medica and pharmacognosy (1895-1904); Ph.G., Maryland College of Pharmacy (1879); M.D., College of Physicians and Surgeons, Baltimore (1883).

1889-91 WILLIAM SCHERER, assistant in chemical laboratory; Ph.G., Maryland College of Pharmacy (1888).

1892-93 CHARLES E. GREEN, assistant in chemical laboratory; Ph.G., Maryland College of Pharmacy (1889); M.D., College of Physicians and Surgeons, Baltimore (1891).

1893-95 W. WAYLAND FRAMES, assistant in chemical laboratory; Ph.G., Maryland College of Pharmacy (1889); M.D., College of Physicians and Surgeons, Baltimore (1892).

1895-1904 DANIEL F. BASE, professor of microscopy and associate professor of chemistry (1895-97), professor of microscopy and analytical chemistry (1897-1900), professor of analytical chemistry and vegetable histology (1900-02), professor of chemistry and vegetable histology (1902-04); A.B., Johns Hopkins University (1891); Ph.D. (1895).

CHARLES SCHMIDT, instructor in pharmacy (1880).

JOHN P. PIQUETT, instructor in botany and pharmacognosy (1900-01), associate professor of botany and pharmacognosy (1900-01), associate professor of materia medica and botany (1901-04); Ph.G., Maryland College of Pharmacy (1871).

1900-04 HENRY P. HYNSON, professor of dispensing and commercial pharmacy (1900-04); Ph.G., Maryland College of Pharmacy (1877).

1902-03 CLAUDE D. HICKMAN, laboratory assistant in pharmacy; Ph.G., Maryland College of Pharmacy (1900).

1902-04 H.A.B. DUNNING, associate professor of chemistry; Ph.G., Maryland College of Pharmacy (1897).

HENRY L. TROXEL, laboratory assistant in chemistry; Ph.G., Maryland College of Pharmacy (1899).

FRANTZ NAYLOR, laboratory assistant in dispensing; Ph.G., Maryland College of Pharmacy (1900).

1903-04 E.F. KELLY, laboratory assistant in pharmacy; Phar. D., Maryland College of Pharmacy (1902).

NOTE: Some of the faculty did not have academic degrees. In some instances, the institution from which degree was obtained and date could not be identified.

University of Maryland
Department of Pharmacy
Faculty

1904-06 JOHN P. PIQUETT, associate professor of materia medica and botany.

CHARLES SCHMIDT, associate professor of pharmacy.

1904-07 FRANTZ NAYLOR, demonstrator of dispensing.

1904-09 HENRY L. TROXEL, demonstrator of chemistry: Phar.D., University of Maryland (1906).

1904-15 H.A.B. DUNNING, associate professor of chemistry; Phar. D., University of Maryland (1907).

1904-16 WILLIAM SIMON, emeritus professor of chemistry.

1904-17 CHARLES CASPARI, JR., professor of theoretical and applied pharmacy, Dean of the faculty; Phar. D. Honorary, University of Maryland (1905).

1904-20 DANIEL F. BASE, professor of chemistry and vegetable histology (1904-20), secretary-treasurer of faculty (1914-18), Dean of faculty (1918-19).

DAVID M.R. CULBRETH, professor of materia medica, botany and pharmacognosy.

HENRY P. HYNSON, professor of dispensing and commercial pharmacy (1904-17), professor of commercial pharmacy and store practice (1917-20); Phar. D. Honorary, University of Maryland (1907)

E.F. KELLY, demonstrator of pharmacy (1904-06), associate professor of pharmacy (1906-17), professor of galenical pharmacy (1917-18), professor of theoretical and applied pharmacy (1918-20), Dean of faculty (1919-20).

1906-10 CHARLES H. WARE, associate professor of botany; Ph.G., MCP (1886).

1906-13 JAMES W. WESCOTT, associate professor of materia medica (1906-07), associate professor of materia medica and pharmacognosy (1907-13); Ph.G., MCP (1889).

1907-12 JOEL J. BARNETT, demonstrator of pharmacy; Ph.G., MCP (1889); Phar. D., (1900).

1907-20 CHARLES C. PLITT, associate professor of vegetable histology (1907-10), associate professor of botany and vegetable histology (1910-13), associate professor of botany, materia medica and vegetable histology (1913-19), professor of vegetable histology and associate professor of botany and materia medica (1919-20); Ph.G., MCP (1891).

J. CARLTON WOLF, demonstrator of dispensing (1907-12), associate professor of dispensing and commercial pharmacy (1912-17); professor of dispensing (1917-20); Phar.D., University of Maryland (1905).

1909-10 ROBERT L. SWAIN, demonstrator of chemistry; Phar. D., University of Maryland (1909).

1910-14 HENRY E. WICH, demonstrator of chemistry, and again from 1919 to 1920 as associate in chemistry; Phar. D., University of Maryland (1909).

1913-20 LOUIS J. BURGER, lecturer on pharmaceutical jurisprudence; Ph.G., MCP (1893); LL.B., University of Maryland (1896).

1914-20 GEORGE A. STALL, demonstrator of dispensing; Phar. D., University of Maryland (1909).

1917-20 FRONTIS LENTZ, demonstrator of pharmacy (1917-18), associate in pharmacy (1918-20); Phar. D., University of Maryland (1914).

1919-20 H.J. MALDEIS, professor of bacteriology; M.D., University of Maryland (1903).

ROBERT L. MITCHELL, professor of physiology and hygiene; Phar.D., MCP (1902); M.D., University of Maryland (1905).

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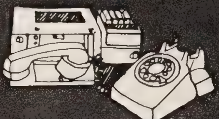

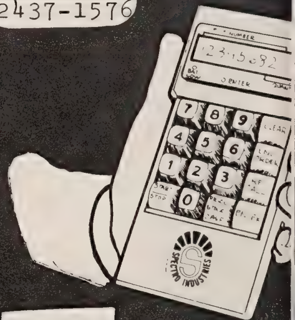

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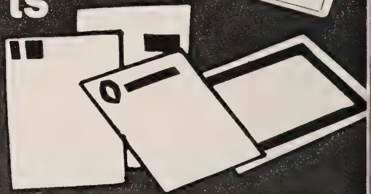

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Proposed Maryland Pharmacy Practice Act

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Marilyn K. Speedie

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President's Message

It would be an understatement to say that this has been a most interesting year for me. Mixed feelings of relief and disappointment greet the realization that my term of office is about over. It will be a relief to shed the responsibility that led almost to feelings of guilt when I forsake Association business to give time to my family and pharmacy, but a disappointment to know that the year slipped by without attaining all of my goals. Some were realized, some will progress through the next administrations, others never got off the ground.

I have always felt that the best way to make your point as an association is to have those persons most involved in the specific area present it. Many groups, such as Med-Chi, have long envied our ability to have pharmacy practitioners appear in Annapolis to testify, rather than relying on staff. Even a highly paid lobbyist cannot tell the story like the person whose economic and professional well-being depends on the outcome of the legislation.

I have pressed in recent years to apply this advantage to Medicaid negotiations, and since those most heavily involved in Medicaid have become active in the name of MPhA, we have been the better for it. Marv Friedman and Don Schumer have led the way this year. Although we have not "won them all" by any means, and at this writing are still knee-deep in a battle for a fee increase this year, an honest appraisal can only show that in most areas our relations with Medicaid are greatly improved. Faster payment, more accurate cost prices, our input allowed when changes are being made — these victories were won because of practitioner involvement. Truly equitable fees will take longer and may take more dramatic activity, but as long as the pharmacists filling the prescriptions press the issue, it will be attained.

Recently, the profession in Maryland has been threatened by non-pharmacist encroachment in enforcement. From a low point last year when it appeared that pharmacists would have no say in inspection techniques which could lead to loss of license, MPhA has made quick strides in making its case known to reverse the trend. Although this certainly will not be completed this year, we have been able to make the agencies involved realize that they are also answerable to the profession. Only practicing pharmacists, those involved, active MPhA members willing to give their spare time for the profession, could get this story across.

Great progress has been made in dealing with other medical professions, largely due to the efforts of Paul Freiman and Sam Lichter. The pharmacists of today are not willing to be a 'silent partner' to the M.D. The best way for us to help the patient is to let him know what we can do for him and to stand up and be counted if someone or some group feels their toes are being stepped on. If it is in the patient's interest, we must expand our professional activities.

Product Selection alone has opened a whole new area where the pharmacist expertise is needed. Patient profiles open wide doors of pharmacist-patient interaction as well as giving you the tools to show the consumer why it is an advantage to deal with you. Fortunately for those pharmacists who feel they need to be more proficient in their profession, Continuing Education programs sponsored by MPhA, School of Pharmacy and others, are available and coordinated by Henry Seidman, who has so many titles, it can best be said only that he works for pharmacy.

Special mention should be given to the Industrial Relations Committee under the leadership of George Stevenson. While the pharmacist is looking to increase his professional horizons, it is more easily accomplished by working with manufacturers and wholesalers, rather than harboring antagonistic feelings caused by not looking at their viewpoints and problems.

I did promise at the beginning of my term to have a free flow of information to all members and, mainly through the Newsletter, feel that this has been accomplished. When I became active in MPhA it was more the exception than the rule that the membership knew what the Board and Officers were routinely doing for them all year, and this caused problems both ways since membership was not able to make known their views. Richard Schulz has helped bring the Journal just about up to date and hopefully, you will be able to receive timely as well as interesting information in THE MARYLAND PHARMACIST. I like to think that the better dissemination of information has been one of the reasons for more interest shown and better attendance at meetings. At least you have known about the crisis-or-two-of-the-month and have been stimulated to participate in the solutions.

One item of old business which we will finally complete at the Convention will be the ratifying of the amendments to the Association Constitution, and for this I owe quite a debt of thanks to Vic Morganroth, among others.

Perhaps my biggest disappointment has been in not being able to spend more time with local groups. I have visited nearly every affiliated association at least once during the year but I know this is not enough. Some of the leaders, such as Jerry Overbeck of the Eastern Shore and Joe Yousem of Upper Bay, have tried hard to stimulate grass roots involvement. Others probably worked as hard but I was not always informed of local activities.

There are many to whom I am indebted for the efforts they put forth this year. Rather than list a 'Who's Who' in Maryland Pharmacy, suffice it to say that whatever has been accomplished this year was done because of the work of the office staff, association officers, committee chairmen, and many others — even a few who would not join the MPhA for personal reasons but contributed to it nevertheless.

When Dick Parker takes over as President he has my promise to work in whatever capacity for him and for Pharmacy. I've enjoyed being President and look forward to being one of hundreds of active members.

I hope to see as many of you as possible in Ocean City. Ron Lubman has arranged a great working vacation for us. Come — Participate — Enjoy!

– Melvin N. Rubin

Maryland Pharmaceutical Association
Spring Regional Meeting — April 21, 1977
Committee Reports

Legislative Committee
Richard D. Parker, *Chairman*

STATUS OF BILLS — 1977 LEGISLATIVE SESSION
(N) = Failed (Y) = Enacted

N	HB #5	To exempt sanitary napkins and tampons from sales tax.
N	HB #45	Would prevent insurance company and non-profit health service plans from revealing contents of insured's medical records unless authorized by insured.
N	HB #125	Directs Board of Pharmacy to promulgate regulations for mandatory patient profiles. MPhA support of this bill is with reservations.
N	HB #162	Providers convicted of fraud in obtaining Medicaid overpayments are liable to the State for triple damages. MPhA supports.
N	HB #177	To require weight or number of tablets dispensed be shown on Rx label. MPhA will not oppose, but recognizes problems involving increasing information on label.
N	HB #394	Restricting rebates to nursing homes by any providers. This bill replaces the existing law which pertains only to pharmacy services (passed in 1975).
N	HB #424	To require every person who sells poisons at retail to be licensed by Dept. of Health and to keep poison registers. Responsibility is being shifted from Board of Pharmacy control. MPhA favors with amendments to retain Board of Pharmacy role and to continue the current exemption for pharmacies for additional license requirements. The annual pharmacy permit now allows for regulation of poison sales.
N	HB #624	Generic Drug (Basilone and Boozer, Balto. County) To require the generic name of a prescription drug be included on prescriptions of drug products.
Y	HB #667	Generic Drugs (Brown & Maurer) To authorize pharmacists to dispense equivalent drugs in some cases.
N	SB #42	Medical Records provides that the cost of hospitalization or medical treatment may be proven by a showing that the charge was submitted and accepted without protest.
N	SB #122	Will require price stickers on merchandise in stores with over $750,000 annual sales.
N	SB #126	To require local departments of social services provide the Medical Assistance ID case number of recipients to providers on request. MPhA favors, wants amendment that social services also be required to tell providers whether person is eligible and dates of eligibility.
Y	SB #418	Generics/Drug Product Selection.
N	SB #615	Shortage of CDS items on audit may be presumed as evidence of illegal dispensing.
Y	HB #744	Placing Pentazocine Lactate Schedule III. This would make Talwin® injection scheduled, but not the tablets. MPhA favors.
N	HB #793	Requiring two (2) consumers on each board. MPhA feels the one consumer on Pharmacy Board adequately represents the lay public.
N	HB #935	Establish the Joint Oversight Committee on Medicaid to consist of twelve (12) legislators.
N	HB #937	Requiring Medicaid bills to be submitted within 90 days of service. MPhA position: this may be insufficient time in some instances.
Y	HB #938	Making Medicaid fraud a felony.
N	HB #1094	Requiring Medicaid bills to be submitted within 6 months. MPhA supports with amendment to provide an additional 90 days for rejected "error" bills returned to provider.
Y	HB #1147	Ensure payment by Medicaid to nursing homes for patients temporarily absent such as for home visits.
N	HB #1165	Restricting Medicaid co-pay to maximum of 25 cents per Rx. MPhA supports.

N	HB #1186	Transfers all of the Environmental Health Administration from Department of Health & Mental Hygiene to Department of Natural Resources except Food and Drug and Radiation Control.
N	HB #1187	Establishing a Department of Environment Protection to include all of the Environmental Health Administration with same exceptions as HB 1186. MPhA's interest is in retention of Division of Drug Control within Health Department.
N	HB #751	Pharmacy — "Business Hours". Require pharmacist to be on duty at all hours pharmacy establishment is open. Unfavorable report.
N	HB #1483	To prohibit health practitioners including pharmacists from refusing to serve medical assistance recipients. MPhA opposed. Unfav. report.
Y	HB #1701	Prohibit possession of counterfeit prescriptions. MPhA favored.
N	HB #1833	Permit Board of Pharmacy to create regulations for Continuing Education. MPhA favors. Favorable report.
N	HB #1834	Require pharmacy to post name and number of pharmacist when closed, or name and location of nearest all night pharmacy. Unfavorable report.
N	SB #799	Require certification of Orthotists and Prostheists. MPhA opposed. Unfavorable report.
N	HB #591	Sunset law.
N	HB #1374	Sunset law.
Y	SB #1194	Board of Pharmacy may issue special Rx permits to University of Maryland School of Pharmacy for radio-pharmacy and dental pharmacy.
N	HJR #43	Setting Joint Oversight Committee on Medicaid.
N	HB #579	Unit Doses for Mentally retarded.

Finance Committee

Stanley J. Yaffe, *Chairman*

The Finance Committee has met and projected a budget of $76,750.00 for 1977. It is based on increasing sustaining member contributions, more advertisements in a Convention issue of the Journal and support from allied groups. Steps have been taken to curtail costs and expenditures as much as possible.

A full review of income and expenditures will be made prior to the Convention and reported on at the annual meeting. A new accounting procedure has been put into effect and will enable us to better see our financial picture.

Drug Control Liaison Committee

Melvin N. Rubin, *Chairman*

A Committee of MPhA members who will form the nucleus of Drug Control Advisory Committee, met this month with Charles Tregoe, Ron Nelson, and Irv Myers.

Drug control agreed to allow inspectors to dispose of unwanted Schedule II drugs during routine inspections and to provide forms shortly so you can be prepared ahead of time. Drug control reaffirmed that the 10 day letter requirement will be stopped. There was some confusion in the Department concerning Mr. Noren's earlier statement, but they will not require the letter after May 1, 1977 (approximately), when all pharmacies will have been expected to have been inspected for the first time under the new system. The department also agreed to send a copy of the inspection report to the home office of chains if requested.

MPhA position that inspections should be on cause only, not routine, was presented, but not accepted. MPhA recommendation that format be changed is being considered and we will be sent the proposed changes when ready. A proposal to eliminate weighted scores will be considered also. Drug Control anticipates changes in recently promulgated CDS regulations. They probably will allow either locked cabinet or dispersal of Schedule II items, as allowed by Federal law. Some technical wording changes were tentatively agreed to, but the department may not accept change from requirement to date back of original on refills. This impedes use of manual or electronic profile systems which are the basis for improved pharmaceutical services. Drug control is concerned with difficulties in auditing Schedule III, IV, V items when profiles are the only record of refill quantities.

Membership Committee

Elwin Alpern, *Chairman*

The Membership Committee of the Maryland Pharmaceutical Association has met twice, October 26 and February 8, since the Fall Regional Meeting. Attending both meetings were Chairman Elwin Alpern, Philip Cogan, Richard Schulz, Executive Director Nathan Gruz, and President Melvin Rubin. The first meeting was also attended by Edward Nussbaum. Membership rolls this year compare favorably to those of last year. The total 1976 membership was 795 plus 77 SAPhA, or 872 compared to a total for 1975 of 769 plus 56 SAPhA or 825. As of April 19, 1977, the Association has 740 members as compared to 627 members the same time last year. The most dramatic increase is seen in SAPhA (the joint APhA-MPhA Student Chapter at University of Maryland School of Pharmacy). Last year's SAPhA members numbered 77 compared to 177 in 1977.

Since the Fall Regional Meeting, MPhA has visited several affiliated associations with its membership message. We have been warmly received by Upper Bay

A-200 Pyrinate® vs. Kwell®

They're both lethal to head lice and crabs.
That's all they have in common.

Safety Active ingredient, pyrethrin. Pyrethins have been in use for over 40 years.

Frequency of usage If necessary, may be used twice in 24 hours.

Effectiveness Kills head lice, body lice, crabs and nits on contact. Highly effective.

Choice of forms Liquid Shampoo in 2 oz. and 4 oz. size for head lice. Gel form especially effective in pubic and perianal areas against crab lice.

Availability At drugstores. With or without prescription.

Safety Active ingredient, gamma benzene hexachloride (lindane). The subject of an FDA Drug Bulletin warning that excessive absorption may cause central nervous system toxicity.

Frequency of usage Not to exceed one repeat use per week.

Effectiveness Kills head lice, body lice, crabs, nits and scabies. Highly effective.

Choice of forms Lotion, Cream and Shampoo.

Availability At drugstores. Prescription required.

A·200
PYRINATE® LIQUID
A PEDICULICIDE
2 FLUID OUNCES
NORCLIFF THAYER INC.
TUCKAHOE, N.Y.
KWELL Shampoo
FOR EXTERNAL USE
WARNING: KEEP OUT OF REACH OF CHILDREN

When lice strike, call the hot line (800) 431-1140.
New York State residents call collect (914) 779-6300 ext. 2503.

FREE. Professional sample kit, literature, information about film strip. Write to Norcliff Thayer Inc., Tuckahoe, NY 10707

Pharmaceutical Association, and Washington County Pharmaceutical Association. Our hope is to reach all the regional organizations, either in conjunction with the School of Pharmacy's Continuing Education Program or by programs sponsored by MPhA.

A general mailing citing the benefits of membership was conducted in the beginning of March. Brochures reached all registered non-member pharmacists in the State of Maryland. Hopefully, we will begin to draw from the pool of active pharmacists who have as yet not joined the Association.

In the near future, the committee plans to conduct a "captain campaign". This will include members of different graduating classes from the University of Maryland School of Pharmacy contacting classmates in an effort to make pharmacists more aware of how MPhA works for the good of the profession and, therefore, the welfare of each individual pharmacist.

Industrial Relations Committee

George A. Stevenson, *Chairman*

Committee meetings, since our report to the 1976 Fall Regional Meeting, were held on December 7, 1976 and February 15 and March 29, 1977.

NEW COMMITTEE MEMBERS:

Mark Golibart — Abbott Laboratories
Alex Credle — Burroughs & Wellcome
Dr. Ralph Shangraw — University of Maryland, School of Pharmacy
Dr. John Ruggiero — Pharmaceutical Manufacturers Association

ACTIONS:

1. Activity continued on the increasing of membership of pharmaceutical sales representatives. We now have new members from Burroughs & Wellcome, Riker, Mead-Johnson, Wyeth, Abbott Labs., Roche Labs., Pfizer Labs., and A. H. Robins Company. We ask the continued support of this project by all association members.
2. Initiation of a "Community Pharmacy Training Program" for new pharmaceutical sales representatives. Bill Brown (Geigy) researched this idea with industry executives and developed a training program outline. Jerry Block heads a subcommittee to develop this program.
3. George Stevenson visited the PMA Pharmacy Relations Steering Committee on January 27, 1977 and reviewed the purpose of our Industrial Relations Committee, outlined our projects, and requested cooperation. We believe some progress was made.
4. Industry representatives (non-members) were sent letters of invitation to attend this meeting.
5. Future meeting to be held of 2 or 3 MPhA members and 2 or 3 PMA personnel as a "workshop session" on standardized labelling format.

The committee would like to see more interest from the membership of MPhA in the following areas:

1. Inform the committee, in writing, of any project you would like to have the committee consider.
2. We need 3 additional retail members and 1 employee pharmacist on our committee. Meetings are held on Tuesday mornings, six times a year, from 10-12 a.m. at the Kelly Memorial Building.
3. The committee has not had any specific problem with industry referred to it, so the assumption has to be made that pharmacy industry relationships are good in Maryland. If a member has a specific problem please submit it in writing, giving all details to the committee.

Continuing Education Committee

Henry G. Seidman, *Chairman*

Since the last report of this committee which outlined the activities which were to be scheduled, all planned functions, with one exception, have been held. The exception is the remaining "Labelling" seminar to be held on April 26, 1977 in Annapolis, Maryland.*

The Association conducted its annual Simon Solomon Economics Seminar on November 4, 1976 at the Quality Inn, Towson. Chairman for this seminar was Kenneth S. Sumida. The theme of the proceedings focused on the entrepreneur in pharmacy and the various factors involved in opening, buying, or expanding one's pharmacy. The keynote speaker was Mr. Paul A. Pumpian, President of Ketchum Marketing Services, Inc.

On Thursday, March 17, 1977 the Association presented the Annual Robert L. Swain Pharmacy Seminar which dealt with both "Regulatory Agencies and The Pharmacist" and "The Pharmacist as an Adviser to the Public on OTC Preparations." A prestigious faculty from federal and state governments and academia was assembled for this seminar. The chairman of the committee was Philip Cogan.

The seminar titled "Labelling and Communicating Drug Information to Your Patient" is co-sponsored by MPhA and the Division of Continuing Education, University of Maryland School of Pharmacy and in cooperation with our local affiliated organizations. Since January 13th, it has been held in six different locations in the state; at meetings of the Baltimore Metropolitan Pharmaceutical Association; Upper Bay Pharmacy Association; Washington County Pharmacy Association; Allegany-Garrett County Pharmacy Association; Eastern Shore Pharmaceutical Society and Prince Georges Montgomery County Pharmacy Association. One area, Anne Arundel County Pharmaceutical Association, remains for the schedule to be completed.

We are appreciative of the cooperation and efforts expended by the local groups on our behalf and we extend special thanks to the Presidents of these groups for their interest and participation.

Details of each program and participating faculty appear in THE MARYLAND PHARMACIST.

Consumer Affairs Committee

Paul Freiman, *Chairman*

The Consumer Affairs Committee this year has been working actively with consumer groups, especially in the area of drug product selection and the role of the Maryland Pharmaceutical Association in its introduction and subsequent enactment. Both in Annapolis and at large meetings held by interested consumer groups, we were able to stress the role of the pharmacist and the need of the patient to consult with their pharmacists on all problems concerning their medications, including the use of generics.

The first meeting I attended as a member of the panel was held at College Park, Maryland on October 5, 1976 and was sponsored by the Mary Pirg organization, a Ralph Nader group; and the Statewide Alliance for Generic Equivalents (SAGE). I was introduced as Chairman of the Consumer Affairs Committee for the MPhA, and my presence on the panel hopefully helped to emphasize the role of our Association in drug product selection, as well as the role of the pharmacist in protecting and maintaining the health of the patient. Approximately 300 people were in attendance at this meeting, and it proved an excellent opportunity to reach a great number with our message.

Subsequently, I was invited to attend the Statewide Alliance for Generic Equivalents Workshop at Prince George Community College on January 24, 1977. Again a large audience of about 400 people were in attendance at this meeting and again, as Chairman of the Consumer Affairs Committee, I was given an opportunity to address this group, and answer their questions on both generics and pharmacy. This workshop was sponsored by Betterment for United Seniors, a statewide alliance of Senior Citizen Groups.

As a result of these meetings and the efforts of SAGE, busloads of senior citizens appeared at the hearing on HB #418 at which time we were again given an opportunity to stress our role in the proposed legislation. We emphasized throughout our support and initial introduction of this legislation 5 years ago, and emphasized that we were not Johnny-Come-Lately's to the issue of generics, but the role of our Association in its continuing efforts to get meaningful legislation passed. It also gave us an opportunity to blunt the last minute support that came from some local chains, who tended to give the illusion that Drug Product Selection was their very own idea. With the support and efforts of these consumer groups a meaningful DPS was passed this year in Annapolis.

At the present time I have received an invitation from Betterment for United Seniors to attend a Victory Party on April 18, 1977. Although at this writing I am not sure if I will be able to attend, I have had an opportunity to discuss DPS with some of the consumer leaders. I feel that the Consumer Affairs Committee will keep working with interested consumer groups, in the attainment of mutual goals, and where there is not a common mutual-

Continued on page 30

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*Editor's Note: The final seminar was held on April 26, 1977 as scheduled.

questions and answers

On Antibiotics

by Marilyn K. Speedie, Ph.D.*

Q. "What is the incidence of aplastic anemia with chloramphenicol? Is it related to dose or route of administrion?

A. Most health professionals are aware of the drastic limitations placed on the rational use of chloramphenicol following the discovery of its serious side effects in 1961[1]. However, there remain some indications for its use (i.e., meningococcal meningitis in persons allergic to penicillin, typhoid fever) and in fact, the list has expended recently with the increasing indicence of ampicillin-resistant strains of *Hemophilus influenzae*. Therefore, ongoing research concerning the incidence and causes of the aplastic anemia is of considerable interest to persons making decisions about the use of the antibiotic.

Also, a recent report[2] on the prescribing habits of 3,409 physicians in Tennessee revealed a significant misuse of chloramphenicol for a variety of non-indicated infections. Clearly, a reinforcement of the importance and severity of the effects of chloramphenicol on the bone marrow is appropriate.

Several studies have examined the incidence of aplastic anemia following chloramphenicol therapy. The results vary somewhat in the incidence found but all lead to the conclusion that there is a definite causal relationship between chloramphenicol therapy and subsequent aplastic anemia. A state-wide study which was performed in California in 1969[3] reported that the calculated risk of dying from aplastic anemia was 1 in 36,118 treated cases, a figure which means the population treated with chloramphenicol is about thirteen times more likely to die from aplastic anemia than the untreated population. More recent studies performed in Sweden[4], West Germany[5], and Israel[6] report similar figures, ranging from an incidence rate of 1 in 11,500 treated cases and a corresponding death rate of 1 in 18,500 treated cases in West Germany to an incidence rate of 1 in 50,000 treated cases reported in Israel. All the studies agree that the fatality rate upon development of aplastic anemia with pancytopenia is somewhat greater than 50%. **All agree that the development of aplastic anemia is independent of the total dose given, duration of treatment, and the age and sex of the patients.** It does not always occur following the first course of chloramphenicol treatment a person has received[4]. The onset of the aplastic anemia occurs following the completion of a course of treatment with a significant number of cases occurring greater than 9 months after the completion of chloramphenicol therapy. One report on the prognosis of patients with aplastic anemia found that the patients receiving total doses less than 30g were more likely to recover than those receiving higher doses[5] and another study reported poorer prognosis for patients with long intervals between exposure to chloramphenicol and development of pancytopenia[7]. They acknowledge, however, that this relationship might be partially explained by delayed diagnosis and therefore, delayed treatment, rather than a truly long latency period.

Whether or not the development of aplastic anemia is related to the route of administration has not definitely been established. Holt[8] observed in 1967 that no cases were reported upon parenteral administration alone. He postulated that the gut flora of a minority of people might be involved in forming a toxic metabolite. He examined children for the presence of an intestinal enterobacteria that was capable of degrading chloramphenicol. This organism was found in the flora of only a low percentage of normal children[8]. However, no attempt was made to link the presence of this enterobacteria with susceptibility to aplastic anemia.

Holt's postulation has not been confirmed and the observation that all aplastic anemia cases after chloramphenicol involved oral administration may simply reflect the predominant usage of the oral route. Recent work[9] on the mechanism by which chloramphenicol causes aplastic anemia suggest that high doses of chloramphenicol may be inhibiting DNA synthesis in bone marrow cells. Since larger than therapeutic doses are required for significant inhibition, Yunis suggests that a metabolite of chloramphenicol, which would have the same effect but at lower doses, may be involved. This metabolite may be produced either in the intestine or in the liver. If the latter is true the effect would be independent of the route of administration. The DNA synthesis inhibition findings may also support the hypothesis, first proposed by Dameshek[10], that some people's bone marrow cells are hypersensitive to the effects of chloramphenicol and respond with aplastic anemia to therapeutic doses. If this theory were true, again the aplastic anemia would be independent of the route of administration. Clearly, more research is needed both on an epidemiological level and on a biochemical level to determine whether the incidence of aplastic anemia is directly related to the

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*Dr. Speedie is Assistant Professor of Pharmacognosy, University of Maryland School of Pharmacy.

The author wishes to acknowledge Rebecca Tominack and Judy Wenzel Smith for their contributions to the literature search, performed as part of the requirements for the Pharmacognosy 442 course.

route of chloramphenicol administration.

It must be remembered as one is discussing aplastic anemia induced by chloramphenicol that this is not the only form of blood dyscrasia induced by chloramphenicol. The more common form involves inhibition of haemopoiesis, occurs during therapy, and is reversible and dose-related[11]. The blood should be monitored during chloramphenicol therapy to detect this form of toxicity. Unfortunately, this procedure in no way excludes the possibility of developing the potentially fatal aplastic anemia sometime following therapy.

Q. "Can the administration of chloramphenicol eye drops lead to aplastic anemia?"

A. At least two cases of bone-marrow hypoplasia subsequent to the use of chloramphenicol eye drops have been reported in the literature[12] [13]. One case involved a patient who had used 0.5% chloramphenicol eye drops regularly for 23 months and the second involved the use of a similar solution for 2 months. Clearly, the causal relationship suggested by these reports is simply speculative although a number of studies have shown a large percentage of cases of aplastic anemia to be associated with chloramphenicol usage[5].

Measurable levels of chloramphenicol have been demonstrated in the aqueous humor after topical administration to the human eye, showing that chloramphenicol can penetrate the cornea. That it can then further penetrate to the systemic circulation from the humor is suggested by the presence of chloramphenicol in the aqueous/vitreous humor by delivery from the plasma following oral or parenteral administration and subsequent clearance from the humor via the plasma[14]. This indicates interchange of chloramphenicol in *both* directions between the eye fluids and the plasma. Thus there is systemic absorption following ophthalmic administration of chloramphenicol. This phenomenon has been demonstrated in cats[15].

Chloramphenicol induced aplastic anemia appears to be not related to dose. **Therefore, it is conceivable that the minute dose absorbed into the blood from ophthalmically administered chloramphenicol would be sufficient to cause aplastic anemia in sensitive individuals.**

If indeed, as Holt suggests, the development of aplastic anemia must involve the oral route of administration, it is still possible to explain the occurrence after the use of eye drops if one considers that the removal of excess administered solution from the surface of the eye is via the lacrimal ducts, a route which will result in ingestion of the antibiotic[12]. Whether or not this is what actually occurred in these cases is a matter of speculation. However, the clinician should be aware of eye drops as a possible vehicle for unsuspected chloramphenicol dosing.

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calendar

June 17-19 — MSHP Seminar, Sheraton Hotel, Ocean City, Maryland
June 19-22 — MPhA Annual Convention, Carousel Hotel, Ocean City, Maryland
October 2-6 — NARD Convention, Washington, D.C.
October 10-18 — MPhA Trip to Rome. Plan NOW!

Pharmacy Faculty Receive Research Grants

Five members of the University of Maryland School of Pharmacy faculty have each received one year grants from the University's Graduate School in Baltimore. The awards are designed to support the research activities of each recipient. Those receiving the grants are: Dr. David G. Hattan, pharmacology and toxicology; Dr. Jerry D. Skarbek, pharmacognosy; Dr. Marilyn K. Speedie, pharmacognosy; Dr. Theodore A. Van der Hoeven, medicinal chemistry; and Dr. Jeremy Wright, medicinal chemistry.

Proposed Maryland Pharmacy Practice Act

The current Maryland Pharmacy Law is a hodge-podge of laws enacted and amended many times since the first section was enacted in 1902.

The following document, the proposed Maryland Pharmacy Practice Act, is being published in its present stage to solicit the opinions of pharmacy practitioners in Maryland. Please direct any and all comments to: Maryland Pharmaceutical Association, 650 West Lombard Street, Baltimore, Maryland 21201.

This document represents the work of the subcommittee to revise the pharmacy practice act created to prepare a new pharmacy act for the State of Maryland.

To assure wide-spread support for the proposal, representatives of every interested organization and segment of the profession were included on the committee. It covers virtually all aspects of pharmacy with sufficient specificity to assure state legislators that by adopting the Model Act pharmacy boards will have the authority and responsibility necessary to perform their functions competently, as well as the flexibility the Board requires to adequately serve and protect the public in our rapidly changing society.

The subcommittee was not under the illusion that the Tripartite would accept this initial draft as a final draft. The members are realistic and hope that any additions or deletions will strengthen the proposal.

To assure wide-spread support for the proposal, representatives of every interested organization and segment of the profession other than those on the committee should be included in future discussions. Future committee meetings should be open and minutes distributed. Drafts should be provided to interested individuals and publicly announced open hearings held to seek comments on the draft.

Prior to the final consideration, a special meeting should be held, for the express purpose of giving detailed explanations to all interested parties of the meanings of the provisions to be voted upon.

Therefore, the members of the subcommittee respectfully submit to the Tripartite Committee the following draft.

The subcommittee intentionally excluded the following areas for reasons specified:

(1) Substitution

The committee believes a proposal will be submitted and approved by the 1977 legislature. However, if no such proposal is approved, appropriate amendments may be added to our revisions.

(2) Continuing Education

The committee discussed this very controversial area and concluded that it should not be a part of the revision. Such a proposal would obstruct smooth passage of the revision. The committee realizes the need for such a proposal but believes that a separate piece of legislation in the future would better serve the profession.

(3) The committee has specifically avoided a limited definition of the "practice of pharmacy." The profession has changed dramatically and will continue to do so. The required skills, standards and functions of a pharmacist have become so numerous that a definition would be not only verbose but would unintentionally omit a skill that will be needed when the revision has been made into law. Many of the allied health professions have not limited their profession strictly to a definition. The pharmacist is a checkpoint in a system of professional responsibility, the functional independence of the pharmacist is regarded as a basic safeguard for the patient requiring the administration of drugs, and this independence is accompanied by legal recognition of the special order of responsibility that a pharmacist bears.

The role of a pharmacist in the sequence of drug therapy is usually thought of as encompassing activities such as the compounding, labeling, and dispensing of medications, as well as assuring their availability and attending to their proper storage. The pharmacist is under a duty upon the receipt of a physician's order to take care that the correct drug, correct dosage form, correct amount, correct strength, and correct labeling, including correct directions and warning of hazards if necessary, are provided. He must also control the storage of his supplies to avoid outdated, decomposed, contaminated, or otherwise altered drugs. Therefore, a pharmacist is under a duty of care that will place upon him a liability for such errors as mislabeling prescription containers, misreading prescriptions, or dispensing drugs of poor quality resulting from incorrect storage conditions or poor procurement procedures. The role described is one which is common to all the roles of pharmacy practice.

The Report of the Study Commission on Pharmacy (1975) emphasized "that pharmacy is a knowledge system in which chemical substances and people called patients interact." The Study Commission recognized skills common to all pharmacists and also indicated that there are additional skills needed for other differentiated roles.

The Committee recognizes that pharmacy should find a means to identify special competencies without proliferating specialty boards and all their resulting problems.

THE MARYLAND PHARMACY PRACTICE ACT

AN ACT concerning the regulation of the practice of pharmacy and related matters. Be it enacted . . .

Article I — Health

Section 100 Title of Act

This Act shall be known as the "Maryland Pharmacy Practice Act."

Section 102 Legislative Declaration

The practice of pharmacy in the State of Maryland is declared a professional practice concerned with the delivery of health care, the identity, quality, use and distribution of drugs. The practice of pharmacy and the distribution of drugs is declared to effect the public health, safety and welfare and is subject to regulation and control in the public interest. It is further declared to be a matter of public interest and concern that the Practice of Pharmacy merit and receive the confidence of the public and that only qualified persons be permitted to practice pharmacy in the State of Maryland. This Act shall be liberally construed to carry out these objectives and the purposes and provisions of this Act shall be construed to serve the best interest of the public.

Section 103 Statement of Purpose

It is the purpose of this Act to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of the Practice of Pharmacy and of the manufacture, production, sale, distribution, dispensing and use of drugs, medications, devices and such other materials as may be used in the treatment of injury, illness and disease.

Section 104 Definitions

1. *Administer* — means the direct application of a drug to the body of a patient by a licensed practitioner, or by his authorized agent, by injection, inhalation, ingestion, or any other means.

2. *Agent* — means an employee or other authorized person who acts on behalf of or at the direction of a manufacturer, distributor or practitioner but does not include a common or contract carrier, public warehouseman or employee thereof.

3. *Authorized Prescriber* — means a duly licensed physician, dentist, veterinarian or other practitioner, authorized by law to prescribe such drugs or medical supplies.

4. *"Board," or "Board of Pharmacy"* — means the State Board of Pharmacy of the Maryland State Department of Health and Mental Hygiene.

5. *Certification of Licenses* — means the printed or engraved document issued by the Board attesting to the fact that the person named has met the requirements of this Act for licensure in the professional category which is named in the document and shall have the authority to provide pharmaceutical services in this State.

6. *College, School, or Department of Pharmacy recognized by the Board* — means an organized faculty and curriculum which, when completed by a registered student, results in the award of a professional degree in Pharmacy, and the organization and the curriculum is accredited by the American Council on Pharmaceutical Education.

7. *Compounding* — means the preparation of pharmaceutical components into medications including, but not limited to, manufacturing, packaging, intravenous admixture or manual combination of ingredients.

8. *Deliver or Delivery* — means the actual, constructive or attempted transfer from one person to another of a drug.

9. *Department* — means the Maryland State Department of Health and Mental Hygiene.

10. *Device* — means an instrument, apparatus, implement, machine, contrivance, implant, in vitro, reagent or other similar related article, including any component part or accessory, which is:
    (i) Recognized in the official compendium;
    (ii) Intended for use in the diagnosis of disease or other conditions or the cure or mitigation, treatment or prevention of disease of man and/or other animals, or;
    (iii) Intended to affect the structure of any function of the body of man or other animals and which does not achieve any of its principal intended purpose through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its principal intended purposes.

11. *Dispensing* — means the act of delivering a drug to an ultimate user by, or pursuant to the lawful order of an authorized prescriber, including the prescribing and administering of the drug and the packaging, labeling or compounding necessary to prepare the drug for delivery.

12. *Distribute* — means the delivery of a drug other than by administering or dispensing.

13. *Distributor, or Wholesaler* — See Sec. 104(49).

14. *Drug* — means:

(1) substance recognize in the official compendium;

(2) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and

(3) substances (other than food) intended to affect the structure or any function of the body of man or other animals; and

(4) substances intended for use as a component of any article specified in clause (1), (2) or (3) of this paragraph, but does not include devices or their components, parts, or accessories.

15. *Drug Store* — See Sec. 104(30)

16. *Executive Secretary* — means the Secretary of the Maryland Board of Pharmacy.

17. *Furnish* — means the actual delivery of a drug, device, or pharmaceutical service to a person or institution entitled to receive the same.

18. *Health Care Facility* — means any clinic, extended care facility, first aid room, hospital, nursing home, pharmacy, sanitarium, or other facility, licensed by the state, or by the United States to provide:

(1) residential or out-patient care, drugs, or devices,

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(2) advice on the maintenance of health, the prevention or mitigation of disease, or

(3) advice on the use and effects of drugs

19. Hemodialysis — means regular treatment by a kidney machine for persons who have permanently lost the function of their kidneys.

Hemodialysis drugs and devices include:

(a) Dialystate
(b) Heparin
(c) Sterile sodium chloride, 0.9%
(d) Local anesthetics as approved by the Board
(e) Needles
(f) Syringes
(g) Dialyzers, delivery systems and their accessory equipment

20. Label, or Labeling, as a verb — means preparing and affixing to the container of a drug a proper and adequate label as described in Section 503.

21. Labeling, as a noun — means all labels and other written, typed, printed, or graphic matters:

(a) upon any drug, device or cosmetic or any of its containers or wrappers, or
(b) accompanying such drug, device or cosmetic

22. Lay Public — means those persons comprising that part of the total population who are not licensed or who do not have certificates of registration as persons engaged in providing some part of health care, or those persons not engaged in the regulation, research, investigation, or manufacture of drugs or devices, or students in the process of education and training to become providers of health care.

23. License — means the privilege to practice a profession or engage in business in compliance with the terms of this Act.

24. Manufacturer — means every person who prepares, produces, derives, propagates, compounds, processes, packages any drug and who distributes such drug to others for resale, compounding or dispensing.

25. Official compendium — means the current United States Pharmacopeia, the current National Formulary, or any supplement to any of them.

26. Patient — means:

(1) the individual for whom drugs are prepared or administered.
(2) the owner or the agent of the owner of the animal for which a drug is prescribed or to which a drug is administered.

27. Person — includes an individual, corporation, partnership and association.

28. Pharmaceutical Services — Pharmaceutical services are all services provided in the practice of pharmacy concerned with the art and science of selecting, preparing, compounding, packaging and dispensing of drugs, medicines and devices used in the diagnosis, treatment or prevention of disease, whether compounded or dispensed on the prescription of an authorized prescriber, or otherwise legally dispensed or distributed, and shall include the proper and safe storage of drugs, the maintenance of proper records thereof, and the responsibility to provide and interpret for patients information to safely and effectively utilize the prescription drug.

29. Pharmacist — See Sec. 104(41) (Registered Pharmacist)

30. Pharmacy — means "Drug Store," or an establishment located at a designated place, comprising persons and facilities assembled for the purpose of providing pharmaceutical services to the public which has applied for and met the requirements for a certificate of registration as stated in Sections 401 and 402.

Comment

The committee intended to provide a definition that would be all inclusive. The various concepts of community pharmacies, institutional pharmacies, quasi-governmental facilities and other numerous types of establishments would be included by this definition.

The intent of the committee was that any time a person or persons dispenses, compounds or provides any other type of pharmaceutical services to the public within designated boundaries, i.e., store, hospital, nursing homes, the health, safety and welfare of the public would be protected by meeting the requirements of certification.

The committee intends that when the definition is read within the context of the definition of pharmaceutical services then "pharmacy" would not be limited to a location. The members believe that there are various requirements for different modes of practice. Therefore, Pharmacy is an area or premises in which the profession of pharmacy is practiced.

31. Pharmacy Extern — means a Registered Student Pharmacist in the College, School or Department of Pharmacy, recognized by the Board, who assists and receives instruction in the offering of pharmaceutical services in an approved Professional Experience Program, approved by the Board.

32. Practitioner — shall mean one of the following:

(1) A physician, dentist, veterinarian or other person licensed, registered or otherwise permitted to distribute and dispense a drug in the course of professional practice in this state.
   a. "Physician" shall mean any person authorized by law to practice medicine in this State.
   b. "Dentist" and "veterinarian" shall mean any person authorized to practice dentistry or veterinary medicine in this State.
(2) A pharmacist permitted to distribute, and dispense or to administer a drug in the course of professional practice in the State.

33. Prescriber — means practitioner as defined in Sec. 104(32).

34. Preceptor — means a person holding a valid certificate of registration as a pharmacist who will offer a

When is a side effect a sign of effectiveness

With Brethine, it is when the highly effective action of the drug affects skeletal muscle as well as bronchial smooth muscle, causing tremor in some patients.

It is important for you, the pharmacist, to realize that Brethine is a β_2-adrenergic agonist. The result of this action will be highly effective bronchodilation (β_2 receptors in bronchial smooth muscle) and, sometimes, tremor (β_2 receptors in skeletal muscle of particularly sensitive patients).

If you are asked about tremor, you should be aware that tremor usually temporary, that it is a sig that Brethine is working and that easier breathing will continue ev after the tremor subsides (usually in a week or two).

Patients should follow a bedtime morning, and midafternoon dosage schedule to avoid overlappin dosage. They should minimize their intake of coffee and other caffeinated beverages and see their physician.

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terbutaline sulfate

Brethine® brand of terbutaline sulfate
Tablets 5 mg., Tablets 2.5 mg. *Before prescribing or administering, please consult complete product information, a summary of which follows:*

Tablets contain 5 mg. (equivalent to 4.1 mg. of free base) or 2.5 mg. (equivalent to 2.05 mg. of free base) of Brethine, brand of terbutaline sulfate.

Indications: As a bronchodilator for bronchial asthma and for reversible bronchospasm which may occur in association with bronchitis and emphysema.

Contraindications: Known hypersensitivity to sympathomimetic amines.

Warnings: *Usage in Pregnancy:* The safety of the use of Brethine, brand of terbutaline sulfate, in human pregnancy has not been established. The use of the drug in pregnancy, lactation, or women of childbearing potential requires that the expected therapeutic benefit of the drug be weighed against its possible hazards to the mother or child.

Usage in Pediatrics: Brethine, brand of terbutaline sulfate, tablets are not presently recommended for children below the age of twelve years due to insufficient clinical data in this pediatric group.

Precautions: Brethine, brand of terbutaline sulfate, should be used with caution in patients with diabetes, hypertension, and hyperthyroidism. As with other sympathomimetic bronchodilator agents, Brethine, brand of terbutaline sulfate, should be administered cautiously to cardiac patients, especi those with associated arrhythmias. Although the co comitant use of Brethine, brand of terbutaline sulfa with other sympathomimetic agents is not recommended, the use of an aerosol bronchodilator of th adrenergic stimulant type for the relief of an acute bronchospasm is not precluded in patients receivin chronic oral Brethine, brand of terbutaline sulfate, therapy.

Adverse Reactions: Commonly observed side effects include nervousness and tremor. Other reported reactions include headache, increased hear rate, palpitations, drowsiness, nausea, vomiting, an sweating. These reactions are generally transient in

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nature, usually do not require treatment, and appear to diminish in frequency with continued therapy. In general, all the side effects observed are characteristic of those commonly seen with sympathomimetic amines.

How Supplied: Round, scored, white tablets of 5 mg. in bottles of 100 and 1,000 and Unit Dose Packages of 100; oval, scored, white tablets of 2.5 mg. in bottles of 100.

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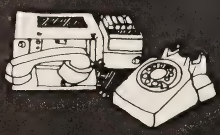

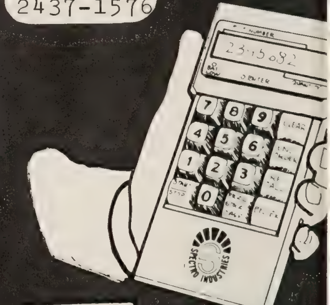

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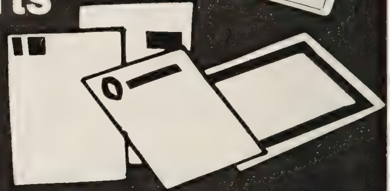

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Professional Experience Program to Registered Student Pharmacists for the purpose of allowing them to qualify for the examination to become pharmacists.

35. Prescription, Medication Order — means and includes any order for drugs or medical supplies, written or signed or transmitted orally, by telephone, or other means of communication to a registered pharmacist by a prescriber.

Comment

The committee intended that this definition would include not only the classical prescription form seen in a community setting, but the physician in-patient order in an institutional setting. With constant innovative methods of communicating a prescriber's order and establishing a retrieval system, a more realistic and less restrictive approach was necessary. Therefore, the committee intended that the definition include concepts of computer technology and other future electronic methods of communications.

The committee also realized that the profession must recognize the possibility that a registered pharmacist and a physician is and will in the future utilize supportive personnel to transmit and transcribe physicians' orders. Therefore the phrase "or other means of communication" would not only include computers but also qualified computer operators who would operate such systems; and would include physicians and pharmacists' supportive personnel who under the control of a physician or a pharmacist would transmit and transcribe a prescriber's order.

The committee intended that the prescriber and the pharmacist would have direct control over supportive personnel with ultimate responsibilities for the actions of such personnel.

36. Prescription Drug — means a drug which, under Federal law, State law, or local law requires an order by a prescriber prior to being dispensed or delivered.

37. Prescription Drug Order — means a lawful written or verbal order of a practitioner for a drug.

38. Prescription Label — means the attachment to the container used by the pharmacist on the drug or device which shall bear information specified by Sec. 503.

39. Professional Services — means any act performed, statement made, advice, warning or recommendation issued in connection with the practice of pharmacy.

40. Proprietary Medicines — means non-narcotic, non-prescription medicines or drugs which are prepackaged, fully prepared by the manufacturer for use by the consumer and labelled in accordance with the requirements of the statutes and regulations of this State and federal government.

41. Registered Pharmacist — means a "pharmacist" which is any person holding a valid certificate of registration as a Registered Pharmacist in the State of Maryland. Such a person has the duty and responsibility of providing pharmaceutical services to the public as defined in Sec. 104(28) in conforming with this Act and supervising any Registered Student Pharmacist when and as a registrant in these categories is employed to assist him in the provision of pharmaceutical services.

42. Registered Student Pharmacist, or Student Pharmacist — means a person registered as a student of pharmacy as specified in Sec. 310.

43. Rules and Regulations of the Board of Pharmacy, or Rules and Regulations — means every statement, properly promulgated under this act, issued by the Board of Pharmacy under this Act, which has for its purposes the implementation of the provisions of this Act.

44. Sale — means and includes traffic in, barter, exchange, disposal, or gift of offer therefor, and each transaction made by any person whether as principal, proprietor, broker, agent, servant, or employee.

45. Secretary — means the Secretary of the State Department of Health and Mental Hygiene.

46. Student Pharmacist — see Sec. 104(42) (Registered Pharmacist)

47. Unprofessional Conduct — means the violation with knowledge or intent, of any of the sections of this Act or of the Rules and Regulations of the Board of Pharmacy.

48. Vending Machine — means a mechanical device that sells or furnishes drugs or devices.

49. Wholesaler, or Wholesale Distributor, or Distributor — means a person who sells drugs or devices to others for resale, compounding, dispensing, or administering any drug that he, himself, has not prepared, produced, derived, propagated, compounded, processed, and packaged. This definition shall include but not be limited to Drug Wholesalers, Physicians' Supply Houses, Surgical Supply Houses, Veterinarians' Supply Houses and others performing the above functions. A pharmacy or other practitioner which occasionally furnishes an emergency supply of drugs or devices to another Regional Pharmacy shall not be considered a wholesaler.

Article II

Board of Pharmacy

Section 201. Designation.

The responsibility for enforcement of the provisions of this Act is hereby vested in the Maryland Board of Pharmacy. The Board shall have all of the duties, powers and authority specifically granted by and necessary to the enforcement of this Act, as well as such other duties, powers and authority as it may be granted by appropriate statute from time to time.

Section 202. Membership.

The Board of Pharmacy shall consist of seven members, one of whom shall be a representative of the public, and the remainder of whom shall be pharmacists who possess the qualifications specified in Section 203.

Comment

The membership of the Board was five members. With the increase to seven members in recently passed legislation the subcommittee agreed to maintain the new seven member status.

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Sec. 203. Qualifications.

(a) Public Member. The public member of the Board of Pharmacy shall be a resident of this State who has attained the age of majority and shall not be nor shall he or she ever have been a member of the profession of pharmacy, or the spouse of a member of the profession, or a person who has ever had any material financial interest in the providing of pharmacy services or any activity directly related to the Practice of Pharmacy.

(b) Licensed Pharmacists. The licensed pharmacist members of the Board of Pharmacy shall at the time of their appointment:

(1) be residents of this State;
(2) be licensed and in good standing to practice pharmacy in this State;
(3) have five (5) years of experience in the Practice of Pharmacy in this State after licensure.

Comment

The requirement that each member of the Board shall be a resident of the State of Maryland will prevent the possibility of a pharmacist living in any of the surrounding states and practicing in Maryland, from becoming a member.

The subcommittee wanted a five year minimum requirement. The five years of experience in the practice of pharmacy would cover all requirements, i.e. compounding and dispensing. If this section included specific qualifications it would not only be redundant but cause confusion.

Sec. 204. Appointments.

The Board members who are pharmacists shall be appointed by the Governor, upon the recommendation of the Secretary of Health and Mental Hygiene from a list of pharmacists by the Maryland Pharmaceutical Association. This would be binding on the Governor. This list would be three times the number of vacancies to be filled.

The Governor shall appoint a public person at large.

Comment

The committee discussed all possible ramifications surrounding the selection of Board members. The problem concerning a representative board, one which was qualified to handle all areas of pharmacy was considered. The need for board members from all areas of pharmacy including the chains, and hospital areas is great. The committee believed that if each area is mentioned there would be a possible exclusion of some group such as "Consultant Pharmacist." The committee, therefore, would seek a document from the Association indicating that the list would be representative of all areas of pharmacy. This document would be attached to the total revision commentary which would show the intent of the law.

Again it must be emphasized that it would be impossible to accommodate all the pharmacy groups in the wording of the statute. There is an ever increasing list of new pharmacy groups and proposed specialties. Every time a new group is formed then the statute would have to be modified to avoid possible conflicts. If this revision is to be one that will accommodate the profession in the future as well as the present, then the proposal must stand as indicated above.

It has been argued that an open selection process whereby all interested groups may submit names to the Governor for appointment would be the better system. Granted, the naming of just one organization may also lead to questionable Constitutional issues. However, by leaving the nomination process open to all groups, the result would be a voluminous list which would lead to inevitable disruption of a smooth selection process.

This section states that the "Governor shall appoint a public person at large." The board represents not only the profession of pharmacy but is also an arm of the state which is governed by the people's representatives. Therefore, the public health, safety and welfare is the job of the Board. There is an increasing awareness by the consumer of the problems they face in the allied health areas. The consumer is increasing his demands on the profession. Public relations with consumer areas has been weak in the past. It is imperative that there be a better understanding of the consumer's problems as they relate to pharmacy. The Public Person would be highly advantageous in offering the Board an input which it lacked previously.

The public person to be of any value must not just sit on the board but also participate in all board duties. This person would eliminate any skepticism the consumer may have over board actions.

This public person should be selected at large by the Governor. The selection should not be related to any list from any Pharmaceutical Association. To avoid any skepticism, the public person should not depend on being nominated by a pharmacy organization.

Sec. 205. Terms of Office.

(a) Length. Except as provided in subsection (b), members of the Board of Pharmacy shall be appointed for a term of three years, except that members of the Board who are appointed to fill vacancies which occur prior to the expiration of a former member's full term shall serve the unexpired portion of such term.

(b) Staggered Terms.

(1) The terms of the members of the Board shall be staggered, so that the terms of no more than two members shall expire in any year.
(2) The present members of the Board shall serve the balance of their terms.
(3) Any member appointed initially for a term of less than five (5) years shall be eligible to serve for two (2) additional full terms.

(c) Successorship. No member of the Board shall serve more than three (3) consecutive full terms. The completion of the unexpired portion of a full term shall not constitute a full term for purposes of this Section.

(d) Commencement. Appointees to full terms on the

Board shall become members of the Board on the first day of the State Fiscal Year next following their appointment. Appointees to unexpired portions of full terms shall become members of the Board on the day next following such appointment.

(e) Expiration. Each term of office on the Board shall expire at midnight on the last day of the State Fiscal Year in the final year of the Board member's term or on the date his or her successor is appointed and qualified, whichever shall later occur.

Comment

The appointment of members of the Board for a term of three years in Section 205(a) was added to allow for more effective re-evaluation.

The committee believed that the above mentioned length of terms would allow for more effective re-evaluation. The term of three years would give a member a period of one to two years to gain awareness and familiarity with his position. In the last year of his initial term he can perform his duties effectively. It was the consensus of the committee that in all probability a member would be renominated unless he has not shown favorable evaluations by the profession.

It has been argued that it takes five years to become functional as a member both in a state-wide and national scale. This argument is rebutted by the renomination of a member. If the member has shown initiative and competence he should not have a problem being renominated.

Section 205(b) allows for at least five experienced members on the Board at one time by staggering so that no more than two members' terms will expire in a year.

Sec. 206. Vacancies.

Any vacancy which occurs in the membership of the Board for any reason, including removal, resignation, death, disability or disqualification, shall be filled by the Governor in the manner prescribed by Section 204. The Governor shall fill vacancies which occur by expiration of full terms within ninety (90) days prior to each date of expiration, and shall fill vacancies which occur for any other reason within sixty (60) days after such vacancy occurs. Any nominating petitions submitted to the Governor pursuant to Section 204 within one (1) year previous to the time when any vacancy occurs may be resubmitted to the Governor to nominate an individual to fill such vacancy.

Section 207. Removal.

(a) Grounds. The Governor may remove a member of the Board, pursuant to the procedures set forth in subsection (b) hereinbelow, upon one or more of the following grounds.

(1) The refusal or inability for any reason of a Board Member to perform his duties as a member of the Board in an efficient, responsible and professional manner.

(2) The misuse of office by a member of the Board to obtain personal, pecuniary or material gain or advantage for himself or herself or another through such office;

(3) The disqualification of any member by reason of the violation of this Act or any of the rules or regulations adopted hereinunder.

(b) Procedures. The following procedures shall be utilized to remove a member of the Board from office for any of the grounds specified by subsection (a) above.

(1) Any person including the Governor or a Board member may file a complaint with the Executive Secretary of the Board against a member of the Board alleging specific facts which constitute grounds for removal from the Board. The Executive Secretary shall notify the President of the Board, the accused member and the Governor of the filing of any such allegations.

(2) Upon the express recommendation of the Governor or two-thirds (⅔) of the members of the Board, a hearing shall be conducted before an impartial hearing officer pursuant to the State Administrative Procedures Act. The hearing officer shall submit a transcript of the hearing to the Governor and shall recommend whether the Board member shall be removed.

(3) The Governor shall review the transcript of any such hearing, determine whether there is substantial evidence to support a finding that a member of the Board has engaged in conduct which constitutes grounds for removal from the Board, and shall enter a finding in accordance with such determination.

Section 208. Organization.

(a) Officers. The Board of Pharmacy shall elect from its members a President and such other officers as it deems appropriate and necessary to the conduct of its business. The President of the Board of Pharmacy shall preside at all meetings of the Board and shall be responsible for the performance of all of the duties and functions of the Board required or permitted by this Act. Each additional officer elected by the Board shall perform those duties assigned to him or her from time to time by the Board.

(b) Terms of Office. Officers elected by the Board shall serve terms of one (1) year commencing with the day of their election, and ending upon election of their successors and shall serve no more than two consecutive full terms in each office to which they are elected.

(c) Executive Secretary. The Board shall employ an Executive Secretary who shall not be a member of the Board but who shall be a pharmacist, a resident of Maryland and licensed to practice pharmacy in Maryland. Upon the approval of the Governor, the Executive Secretary shall be installed and shall serve during the pleasure of the Board. The Secretary shall be a full-time employee of the Board and shall receive compensation commensurate with the duties and responsibilities of the position. Specifications outlining the duties and responsibilities of the executive secretary shall be prepared by the Board.

Comment

This section speaks of an executive secretary. The executive secretary will perform the day to day functions of the Board. This officer should be a pharmacist to handle daily business efficiently. The committee discussed the possibility of a non-pharmacist as a secretary but this was rebutted by the argument that a pharmacist would be more capable and competent to discuss and be aware of pharmacy issues. The committee left the matter of salary and job description defining his duties to the Board.

Section 209. Compensation.

(a) Board Members. Each member of the Board of Pharmacy shall receive, as compensation, the sum of $75 per day for each day upon which the member is engaged in performance of official duties of the Board, and reimbursement for all expenses incurred in connection with the discharge of such official duties.

Section 210. Meetings.

(a) Number. The Board of Pharmacy shall meet at least once every month to transact its business. One such meeting shall be for the purpose of electing officers and for the reorganization of the Board. The Board shall meet at such additional times as it may determine. Meetings shall be called by the President of the Board or by two-thirds (⅔) of the members of the Board.

(b) Place. The Board shall meet at such place as it may from time to time determine. The place for each meeting shall be determined prior to giving notice of such meeting and shall not be changed after such notice is given without adequate subsequent notice.

(c) Notices. Notice of all meetings of the Board shall constitute a quorum for the conduct of a Board meeting, and, except as otherwise provided in this Act, all actions of the Board shall be by a majority of a quorum.

(d) Open Meetings. All board meetings and hearings shall be open to the public. The Board may, in its discretion and according to law conduct any portion of its meeting in executive session closed to the public.

Comment

This section allows for a designated schedule of meetings with discretion in the Board to schedule such additional meetings as may be needed from time to time to accomplish the Board's work. All meetings should be announced by appropriate public notice and should be open to the public.

This section will give the Board the widest latitude possible in this regard because of the relative ease in which rules and regulations can be amended. To be specific in the statute would require legislative amendments from time to time which are more difficult to achieve and at times delayed for a long period of time by reason of the political process.

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Section 211. Employees.

(a) Authority. The Board of Pharmacy may, in its discretion, employ persons in addition to the Administration Officer in such other positions or capacities as it deems necessary to the proper conduct of Board business and to the fulfillment of the Board's responsibilities as defined by this Act.

(b) Compensation. The employees of the Board other than the Executive Director shall receive, as compensation, an annual salary payable ________, the amount of which shall be determined by the Board and reimbursement for all expenses incurred in connection with performance of their official duties.

Comment

This section gives to the Board the power to employ persons in addition to the Executive Secretary. The committee discussed the budgetary problems surrounding the Board section. It was the unanimous agreement of the committee to assume the present budget and include the salaries of the executive secretary, staff employee, and a field representative. The members of the committee indicated a need for a field representative to handle normal board inspections other than those performed by the Division of Drug Control. In separating the Board from Drug Control Division the workload of the present inspectors would be alleviated. Therefore, one person should be transferred to the Board. The salaries would be:

(1) Executive Secretary — $21,000-$25,000
(2) Office Helper — $7,500-$8,500
(3) Field Representative ________

Section 212. Rules and Regulations.

(a) Authority. The Board of Pharmacy shall make, amend and repeal such rules and regulations as may be deemed necessary by the Board, from time to time, for the proper administration and enforcement of this Act. Such rules and regulations shall be promulgated in accordance with the procedures specified in the Administrative Procedures Act, Article 41, Sec. 244 to 256, inclusive.

Section 213. Licensure and Discipline.

(a) Responsibility. The Board of Pharmacy shall be responsible for the control and regulation of the Practice of Pharmacy in this State including, but not limited to, the following:

(1) The *licensing* by examination or reciprocity of applicants who are qualified to practice pharmacy under the provisions of this Act;
(2) The *renewal* of licenses to practice pharmacy;
(3) The enforcement of those provisions of this Act relating to the conduct or competence of pharmacists practicing in this State, and the suspension, revocation or restriction of licenses to practice pharmacy.

Section 214. Medications, Drugs, Devices and Other Materials.

(a) Responsibility. The Board of Pharmacy shall also have the responsibility for the control and regulation of medications, drugs, devices and other materials used in the diagnosis and treatment of injury, illness and disease, including, but not limited to the following:

(1) The regulation of the manufacture, production, sale, distribution and use in this State of medications, drugs, devices and other materials used in the treatment of injury, illness and disease;
(2) The specification of minimum professional and technical equipment, environment, supplies and procedures for the compounding and/or dispensing of medications, drugs, devices and other materials used in the diagnosis and treatment of injury, illness and disease in this State;
(3) The control of the purity and quality of medications, drugs, devices and other materials used in the treatment of injury, illness and disease, and the manner of sale and distribution of such items;
(4) The regulation of the training, qualifications and employment of pharmacy externs;
(5) The issuance and renewal of permits for the operation of pharmacies, manufacturing and distribution facilities.

Section 215. Other Duties, Powers and Authority.

The Board of Pharmacy shall have such other duties, powers and authority as may be necessary to the enforcement of this Act and to the enforcement of Board rules and regulations made pursuant thereto, which shall include, but are not limited to, the following:

(a) Professional Associations. The Board may join such professional organizations and associations organized exclusively to promote the improvement of the standards of the Practice of Pharmacy for the protection of the health and welfare of the public and whose activities assist and facilitate the work of the Board.

(b) Bond. The Board may require such surety bonds as it deems necessary to guarantee the performance and discharge of the duties of any officer or employee receiving and disbursing funds.

(c) Seal. The Executive Secretary of the Board shall keep the seal of the Board and shall affix it only in such manners as may be prescribed by the Board.

(d) Reports. On or before the 60th day after the last day of each State Fiscal Year, the Board shall submit to the Governor a report summarizing its proceedings and activities during that Fiscal Year, together with a report of all monies received and disbursed by the Board. Such reports or comprehensive summaries or abstracts thereof, as determined by the Board, shall be made available to the public.

(e) Fees. (1) Amount. The Board shall determine within thirty (30) days prior to the beginning of each State Fiscal Year the fees to be collected for:

(i) Examinations and re-examinations, which fee shall not exceed $________;
(ii) The issuance of licenses and renewal licenses, which fee shall not exceed $______; and

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(iii) The issuance of permits and renewal permits, which fee shall not exceed $______; and

(iv) The certification of approved providers of continuing education courses, which fee shall not exceed $______.

(f) Procedure. Except as otherwise provided to the contrary, the Board shall exercise all of its duties and powers of authority in accordance with the State Administrative Procedures Act, Article 41, Section 244 to 256, inclusive.

(g) Miscellaneous. The Board shall also have power to investigate and gather evidence concerning alleged violations of the provisions of this Act or of the rules and regulations of the Board.

Article III
Licensure of Pharmacists

Section 301. Applicability.

(a) The provisions of this Act shall apply to all persons in this State engaged in the Practice of Pharmacy, and to all persons in this State engaged in the manufacture, production, sale, and distribution of medication, drugs, devices and other materials used in the treatment of injury, illness and disease.

(b) (i) It shall be unlawful for any person to engage in the Practice of Pharmacy unless licensed to so practice under the provisions of the Act; provided, however, physicians, dentists, veterinarians, osteopaths or other practitioners of the healing arts who are licensed under the laws of this State may dispense and administer prescription drugs in the practice of their respective professions where specifically authorized to do so by statute of this State.

(ii) Any person who shall unlawfully engage in the practice of pharmacy shall be guilty of a misdemeanor and, also, shall be subject to the penalties set forth in Section ____ (Disciplinary section).

Section 302. Qualifications for Licensure by Examination.

To qualify for a pharmacist's license, an applicant shall fulfill the following requirements:

(1) Application: file an application with the department.

(2) Education: have received an education, including a bachelor's or equivalent degree in pharmacy, in accordance with the Board's regulations.

(3) Experience: Have a structured experience program satisfactory to the Board and in accordance with the Board's Regulations.

(4) Examination. Have successfully passed an examination given by the Board of Pharmacy.

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(5) Age: be at least twenty-one years of age.

(6) Citizenship: be a United States citizen, or file a declaration of intention to become a citizen in accordance with the Board's rules and regulations.

(7) Character: be of good professional character as determined by the Board.

(8) Paid the fees specified by the Board of Pharmacy for examination and issuance of license.

Section 303. Examinations.

(1) The examination for licensure required under Section 302 of the Act, shall be given by the Board at least two (2) times during each fiscal year. The Board shall determine the content and subject matter of each examination, the place, time and date of administration of the examinations, and those persons who shall have successfully passed the examination.

(2) The examination shall be prepared to measure the competence of the applicant to engage in the Practice of Pharmacy. The Board may employ and cooperate with any organization or consultant in the preparation and grading of an appropriate examination, but shall retain the sole discretion and responsibility of determining which applicants have successfully passed such an examination.

Section 304. Externship.

(1) All applicants for licensure by examination shall obtain practical experience in the Practice of Pharmacy concurrent with or after college attendance, or both, under such terms and conditions as the Board shall determine.

(2) The Board shall establish standards for externship necessary to qualify an applicant for the licensure examination and shall also determine the necessary qualifications of any preceptors used in any externship.

Section 305.

The Board shall keep a book in which shall be registered the names and places of business of all persons so registered, and so contain all facts pertaining to the granting of certificates.

Section 306. Renewal of Licenses.

Certificate of Renewal:

The Board shall issue every two years a certificate of renewal to a pharmacist upon application. Such certificates shall be secured every two years on or before the last day of September upon payment of a fee of $15.00. Any pharmacist who fails for any reason to register or reregister within the time prescribed shall pay an additional fee of $2.00 for each renewal period that he shall fail to register or reregister.

Section 307. Reciprocal Registration, Qualifications for Licensure.

(1) The Board may in its discretion license as a Registered Pharmacist, without examination, any person who is duly licensed as a Pharmacist by examination in some other state provided that the person produces evidence satisfactory to the Board of having had the required professional education and training as required by applicants for licensure as Pharmacists under the provisions of this Act.

(2) Persons who have become licensed as Pharmacists by Examination in other states prior to the effective date of this Act shall be required to satisfy only the requirements for licensure as Pharmacist which existed in this State at the time they became registered as pharmacists in such other states and provided also, that the state in which each such person is licensed shall, under like conditions, grant reciprocal registration as a Registered Pharmacist, without examination to a Pharmacist duly licensed as such by examination in this State.

(3) All applications for licensure as a Pharmacist by reciprocity shall be made on a form supplied by the Board and accompanied by satisfactory proof of compliance with the above requirements. Each application shall be accompanied by a filing fee as determined by the Board. The person who shall be licensed as a Pharmacist by reciprocity, under the provisions of this Section, shall have the authority to provide pharmaceutical services in this State.

Section 308. Fees.

Each person applying for licensure as a pharmacist under this chapter shall pay to the executive secretary of the Board, the fees provided by this Article, on filing his application, and which shall be compensation to the Board.

Section 309. Proof.

Proof of the qualifications of any applicant for licensure as a pharmacist, shall be made to the satisfaction of the Board and shall be substantiated by such affidavits or other evidence as may be required by the Board. Anyone swearing falsely in the affidavits or other evidence shall be deemed guilty of perjury.

Section 310. Registration — Student of Pharmacy.

Any person enrolling as a student in a College, School or Department of Pharmacy, recognized by the Board shall file with the executive secretary within 30 days from the date of enrollment an application for registration as a pharmacy extern. All pharmacy externs at the beginning of any subsequent college year, shall submit to the Board a sworn statement of any Professional experience acquired during the preceding year. Each person registering under this section shall pay to the Board a fee of one dollar.

Article IV

Registration of Facilities

Section 401. Pharmacy Permit.

No person shall conduct a pharmacy or provide pharmaceutical services in the State of Maryland unless he has obtained a certificate, license, permit or registration from the Board. Each certificate, license, permit or registration shall be required for each place of business owned or operated by a specific person. Separate certificates, licenses, permits or registrations shall be required for each of the premises of any business establishment having more than one location. Such certificate, license, permit or registration shall be renewed every two years on or before November 1 of every other year and shall not be transferrable.

Section 402. Pharmacies.

(a) To obtain a permit under Section 401 the following proof satisfactory to the Board must be presented:

(1) That the pharmacy for which the permit is sought will be conducted in full compliance with the rules and regulations of the Board.

(2) That the location and appointments of the pharmacy are such that it can be operated and maintained without danger to the public health or safety.

(3) That the pharmacy will be constantly under the personal and immediate supervision of a pharmacist.

(4) That the pharmacy shall offer pharmaceutical services as reasonably required by the Board.

(5) The pharmacy shall not offer professional services under terms and conditions which tend to interfere with or impair the free and complete exercise of professional judgment and skill or enter into any agreement which denies the patient the right of free choice of pharmacists.

Section 403. Wholesaler's Permit.

(a) No person shall act as a wholesaler unless he has obtained a permit or exemption from the Board. Upon approval thereof by the Board and the payment of the required fee as determined by the Board, the Board shall issue a permit or exemption to such applicant.

(b) No selling or distribution outlet, located in this state, or any out-of-state manufacturer, which has not obtained a permit or exemption from the Board, which sells or distributes only the drugs of such manufacturer, shall sell or distribute any drug in this State without obtaining a wholesaler's certificate, license, permit, registration, or exemption from the Board.

(c) Each permit or exemption shall be required for each place of business owned or operated by a specific person. Separate certificates, licenses, permits, registrations or exemptions shall be required for each place of business owned or operated by a wholesaler. Such certificates, licenses, permits, or registrations shall be renewed annually on or before ________ of each year, and shall not be transferrable.

Section 404. Manufacturer's Permit.

(1) No drugs, medicines, toilet articles, or cosmetics, shall be manufactured within this State, except under the personal and immediate supervision of a registered pharmacist or any other person as may be approved by the Board.

(2) No person shall manufacture without first obtaining a permit from the Board.

(3) Such permit shall be subject to such rules and regulations as the Board may adopt for the protection of the public health and safety.

(a) The application for such permit shall be made on a form to be prescribed and furnished by the Board and shall be accompanied by the required fee of $________.

(b) Renewal: The fee stated in (a) shall also be paid as the fee for each renewal of the initial permit.

(c) Separate applications shall be made and separate permits issued for each separate place of manufacture.

(d) Permits issued under the provisions of this section shall be exposed in a conspicuous place in the place for which it was issued.

(e) The permit shall not be transferrable. The permit shall expire on the last day of December following the date of issue and shall be renewed annually.

Section 405. Permits.

(a) Upon refusal of an application for a permit under Section 401, 402, 403, 404, the Board shall notify the applicant in writing of its decision and the reasons therefor.

(b) Renewal and revocation; late fee. Application blanks for renewal permits shall be mailed by the Board to each permittee on or before November 1st in each year, and if application for renewal is not made on or before the following 1st day of December, the existing permit shall lapse and become null and void on the date of its expiration, and no new permit will be granted except: (1) upon evidence satisfactory to the Board of good and sufficient grounds for the failure to file the application for renewal within the time prescribed; and (2) upon payment of a late fee of $5, in addition to the renewal fee.

The Board shall make such rules and regulations, not inconsistent with law, as may be necessary to carry out the purposes and enforce the provisions of this section, and is hereby authorized, after due notice and opportunity for hearing, to revoke any permit when examination or inspection of the pharmacy shall disclose that such pharmacy is not being conducted according to law or is being so conducted as to endanger the public health or safety.

(c) Permits issued under this section shall be exposed in a conspicuous place in the pharmacy for which issued. Such permits shall not be transferrable; shall expire the last day of December following the date of issue, and shall be renewed periodically as determined by the Board.

(d) (i) Appeal. Any person to whom the Board has refused to issue a permit, or whose permit has been revoked may appeal from the decision and order of the Board to the circuit court of the county in which the pharmacy or proposed pharmacy in question is or is intended to be located, and if the same is or is intended to be located in Baltimore City, to the Circuit Court or Circuit Court No. 2 of Baltimore City. The Board may stay its order pending the determination of such appeal.

(ii) Penalty; disposition of fee. Any person, violating any of the provisions of this section shall, upon conviction, be deemed guilty of a misdemeanor and fined not more than one hundred dollars ($100) for each offense, and each and every day such violation continues shall constitute a separate and distinct offense.

Section 406. Experimental Programs.

In order to enable any accredited School of Pharmacy recognized by the Board to experiment with new and innovative methods for drug handling, teaching, research, or to develop new and better methods or concepts involving the practice of pharmacy, the Board may enact the following:

(a) The application of particular provisions of the Pharmacy Laws. Article 43, Section 401 to Section 404, may be waived as to an accredited School of Pharmacy recognized by the Board if the Dean of the School has filed with the Board an experimental plan or program which specifies the particular provisions to be waived, and which has been approved by the Board.

(b) Any plan or program approved by the Board shall have: definite time limitations; progress reports which shall be filed as required by the Board.

(c) The Board may rescind approval and terminate said plan or program at its discretion, at any time it may deem the public interest is not fully protected; nor shall any such plan or program be approved by the Board if such proposal might jeopardize public health and welfare.

Section 407. Hemodialysis Exemption.

Sections 401 to 404 shall not apply to a manufacturer, wholesaler, or other supplier of hemodialysis drugs and devices distributed directly to patients if the Board shall find that sufficient, qualified supervision is employed by such manufacturer, wholesaler, or supplier adequately to safeguard and protect the public health. Each person so exempted shall pay to the Board a fee to be set by the Board not to exceed one hundred dollars ($100) per year. Failure to pay such a fee within 60 days after notice by the Board shall void such exemption.

Article V

Miscellaneous

Section 501. Pharmaceutical Utensils.

The Board shall determine the minimum professional and technical equipment which a pharmacy shall at all times possess. No permit shall be issued or continued for a pharmacy until the provisions of this section have been complied with.

Section 502. "Official Compendium" to be kept on hand.

There shall be on file at all times in every pharmacy the latest decennial revision of an official compendium. No permit shall be issued or continued for a pharmacy until the provisions of this section have been complied with.

Section 503. Prescription Label Requirements.

(a) A pharmacist shall dispense a prescription in a container with a label affixed to the container with the following:

(1) Except where the prescriber indicates otherwise, the trade name of the drug, or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by a brand or commonly used name of the principal active ingredients.
(2) The directions for the use of the drug.
(3) The name of the patient.
(4) The name of the prescriber.
(5) The date of original filling.
(6) The name and address of the pharmacy.
(7) The serial (or prescription) number of the prescription.
(8) The strength of the drug or drugs prescribed.
(9) The quantity of the drug or drugs prescribed.

(b) No person shall alter, deface, or remove any label so affixed so long as any of the original contents remain. Any person failing to observe the provisions of this section is guilty of a misdemeanor, and upon conviction thereof, shall be fined fifty dollars ($50). Pharmacists violating this section shall be subject to disciplinary action by the Board of Pharmacy as stated in Section ____.

Article VI

Other

Section 601. Severability.

If any provision of this Act is declared unconstitutional or illegal, or the applicability of this Act to any person or circumstances is held invalid by a court of competent jurisdiction, the constitutionality or legality of the remaining provisions of this Act and the application of this Act to other persons and circumstances shall not be affected and shall remain in full force and effect without the invalid provision or application.

Section 602. Effective Date.

This Act shall be in full force and effect ____ days after its enactment.

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Committee Reports

(continued from page 9)

ity, at least a common meeting ground for discussion of our differences. I think we should continue to work with SAGE to make sure that HB #418 does provide the recognized benefits, and to emphasize to the consumer it is in their interest to develop a personal relationship with their pharmacist both for their economic as well as their health benefits. To this role, the Consumer Affairs Committee will continue striving.

Joint Practices Committee of the Med-Chi (State Medical Society)

Paul Freiman, *Representative*

Although not a Committee of the MPhA, the Joint Practices Committee does call for pharmacy representation, and as our Association's representative, I felt that this report would be in order at this meeting.

The first meeting of the Committee was held on November 3, 1976 at the Med-Chi building. At this meeting letters were brought up from two physicians objecting to pharmacists discussing medication with patients and the use of auxiliary labeling. In the subsequent minutes of this meeting it was pointed out that the pharmacy representative took exception pointing out that it was the responsibility of any pharmacist to reinforce instructions when given by the physician, or give instructions where none were given. The chairman, Dr. Albert M. Antlitz, felt that after receiving a response from our Association it might provide an excellent opportunity to educate physicians, as well as develop guidelines for the use of auxiliary labels. The excellent Drug Interaction Auxiliary Guide prepared under the Chairmanship of Donald Fedder, under the auspices of the Tripartite Committee, should serve to help both MD's and pharmacists to understand the problem. I have recommended to Don Fedder that this guide be distributed to as many physicians as possible.

As a result of this meeting two position papers were sent to Med-Chi from our Association on the overutilization of Tranquilizers, and the use of Multiple Prescription forms. Both problems were referred to the Committee on Drugs of the Medical Association, with what I feel were positive results. At a meeting called by their Chairman, Dr. Kennard Yaffe, on March 15th, the following results were obtained. Since I was unable to attend personally, Sam Lichter and Robert Snyder ably represented our Association. After this meeting, a letter was received from Dr. Yaffe. Also as a result of this meeting the Med-Chi's Executive Director's Newsletter contained the following on Rx Blank Writing: "The Faculty's Committee on Drugs has received numerous complaints with respect to the writing for more than one drug on a prescription blank, especially when one or more controlled dangerous substances such as narcotics are prescribed on the same form with non-CDS drugs. This makes filing and record keeping by the pharmacist very difficult, and also these forms lend themselves to abuse by patients or unauthorized persons in whose hands they may fall. The committee requests that physicians limit writing of all drugs to a single medication on each prescription blank."

Due to my inability to attend, our Executive Director, Nathan Gruz, attended the meeting of March 2nd. He reported the following agenda and actions:

1. Nurse dispensing and reconstituting at Baltimore City Health Dept. Clinics. MPhA and Nurses' Association had agreed several years ago that this practice should be stopped. The Committee consensus was that as the practice was illegal the nurses and pharmacists should form a subcommittee to develop a general policy.
2. Complaints by two physicians against pharmacist counseling and auxiliary labels. The joint policy statement of the Academy of Internal Medicine and APhA was cited in support of the MPhA position which was stated in a previous letter to Med-Chi by Mr. Gruz. It was then agreed that a copy of the MPhA letter should be sent to the doctors. The letter supports the use of auxiliary labels and verbal instructions by pharmacists to patients.
3. Parke Davis stamping of Rx's with statements that PD generics may be dispensed. The Committee felt it was both unethical and commercial. It was referred to Med-Chi Ethics Committee.
4. Physician Pharmacist Code of Cooperation adopted by Med-Chi and MPhA in 1967. Mr. Gruz suggested it was time for an update. A joint MPhA-Med-Chi committee will meet in this project.

In conclusion, I feel that we have opened new areas of communication with the medical profession through our representation on this committee. I feel that it is through such meetings we can emphasize the role of the pharmacist in working with the physician to provide better medical care for the patient.

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What Is Legislative Representation Worth?

An Editorial

Association Membership Directory — 1977

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Thursday, October 27, 1977

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MAY 1977 VOL 53 NO 5

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What Is Legislative Representation Worth?

The record of the 1977 session of The Maryland General Assembly adhered to the pattern of the past decade — an ever increasing number of bills affecting health care in general and pharmacy specifically were introduced.

> Most of the bills the Association sponsored or favored were enacted, but in addition it was of vital importance that *no bill which we opposed was enacted.*

Among the important bills which we opposed and which failed were: to remove the jurisdiction of The Board of Pharmacy over the sale of poisons and to require an additional "poison permit"; to require two consumers on all boards (The Board of Pharmacy has one excellent public member); to require submission of Medicaid bills within 90 days of service; to require certification of orthotists and protothists. Unfortunately a bill for continuing education also failed.

In the list of bills which were enacted were: classifying Medicaid fraud a felony; prohibiting possession of counterfeit prescriptions and permitting the issuance of special pharmacy permits to the University of Maryland School of Pharmacy for a dental pharmacy and a radio-pharmacy. *Most important was the enactment and signing into law of the best drug product selection law in the land, H.B. 667 introduced by delegates Torrey Brown (M.D.) and Lucille Maurer.* This was the culmination of tremendous efforts by members and staff of MPhA supported by consumer groups. MPhA presented the initial draft, but the final version was the result of compromise and amendments.

On balance, all of us can be proud of the Maryland drug product selection law which will become operative January 1, 1978. All drug products unless listed in a "negative formulary" will be covered. Pharmacists will be required to pass on any savings and to notify the patient if a "product selection" has been made. Of course, the legislation is optional — not mandatory. Physicians may indicate "dispense as written" and pharmacists may choose not to exercise drug product selection. Thus pharmacists will have a greater professional role in the selection of prescription medication, consumers will benefit and the prices at the manufacturer level will be more competitive.

So 1977 was another year that ended with an excellent batting average at the annual confrontation with the legislature at Annapolis.

> If a state pharmaceutical association performed no other service, but legislative representation — "lobbying" — the dues would be worth many times what is paid.

All pharmacists owe a great debt of gratitude to those relatively few who actively participate in the MPhA legislative efforts and who recognize the need to contribute to pharmacy's political action as well.

– *Nathan I. Gruz*

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND THE PATIENT.

Pharmacy today is in the spotlight, subjected to all kinds of scrutiny. Your actions are being monitored and judged, sometimes by unknown third parties.

The worry is that in the wake of this focus, your relationships with both doctors and patients will be weakened, without offsetting benefits. Consider three examples:

Drug substitution Until recently, state pharmacy laws, regulations, or professional custom have stipulated that non-generic prescriptions be filled with the precise products prescribed. But in the last five years, a number of these laws or regulations have been changed, permitting you, in varying degrees, to make the selection when a multi-source product is ordered.

These changes have been taking place against a background of growing evidence that purportedly-equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA has not enforced the same standards for hundreds of "follow-on" products that it has applied to original NDA approvals. This situation, it seems to us, is a compelling reason for product selection to rest on a sensible interchange between doctors and pharmacists—and not on legislative action.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant overall savings has been produced, nor is any likely, given the needs of pharmacy and the record of government in administering cost control programs.

MAC Maximum Allowable Cost, MAC for short, is a federal regulation intended to cut the government's drug bill by setting price ceilings for multi-source drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right, regardless of your economic or professional judgments. Pharmacists will have little to say about administration of the program, since government will have absolute authority to make its prices and fees stick. For other multi-source drugs on the MAC list, your reimbursement would be limited to a product price on a government "estimated acquisition cost" list and a state-established professional fee.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to patients: the cost of the research is more than ten times what it was, per product, in 1962, and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years or more now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present complex approval process contributes to needless delay of drug therapy. That's why the increased efficiency of the drug and device approval process is vital to all our futures.

We suggest you make your voice heard on these issues—among your colleagues and your representatives in state legislatures and in the U.S. Congress.

It could make a difference to patients and to the practice of your profession tomorrow.

P·M·A

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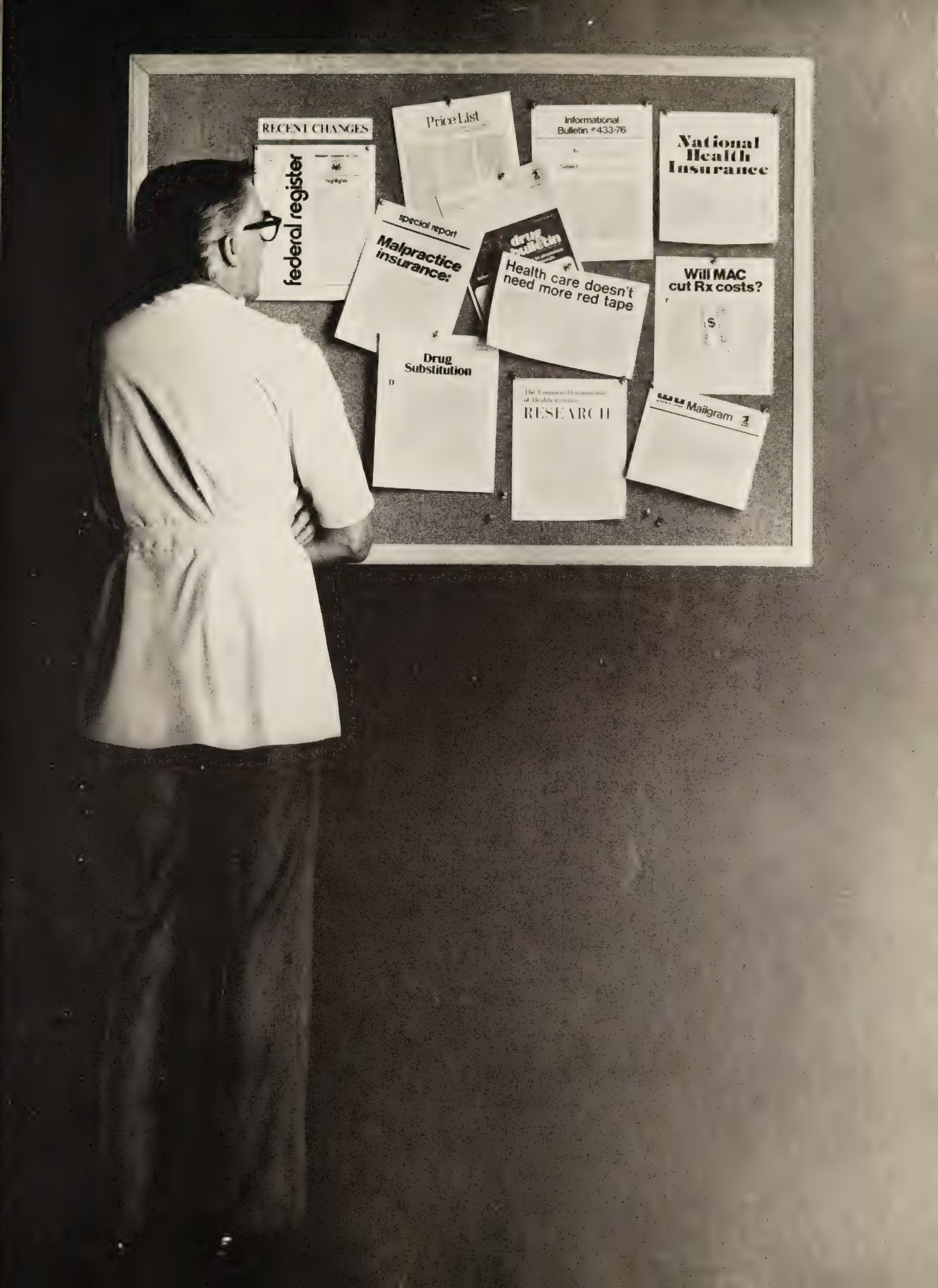
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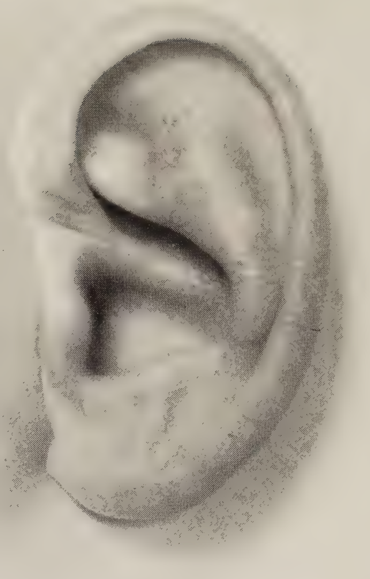

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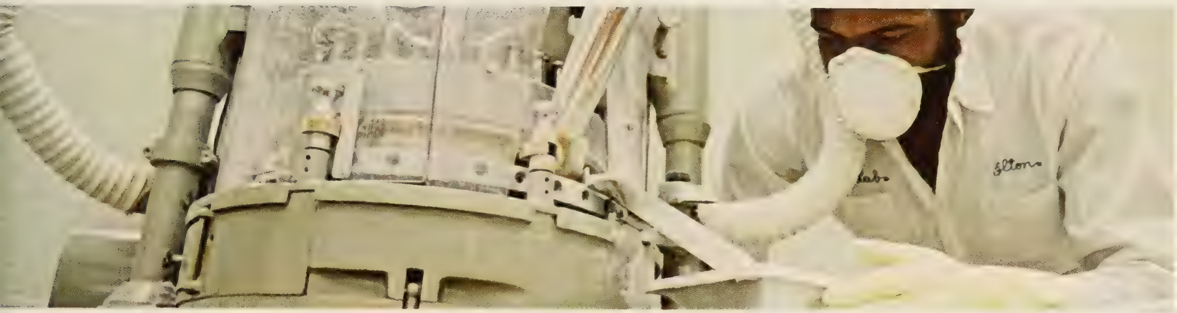

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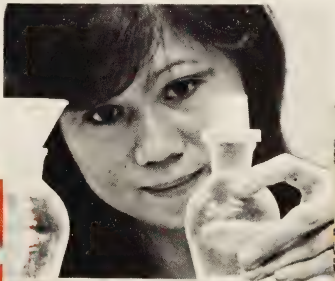

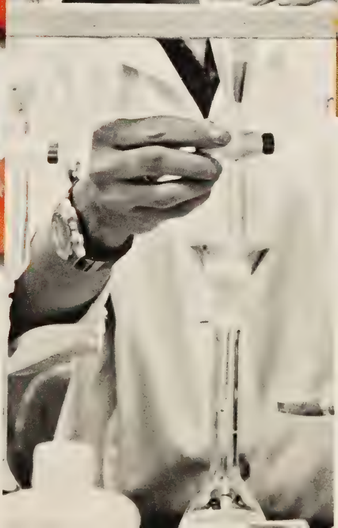

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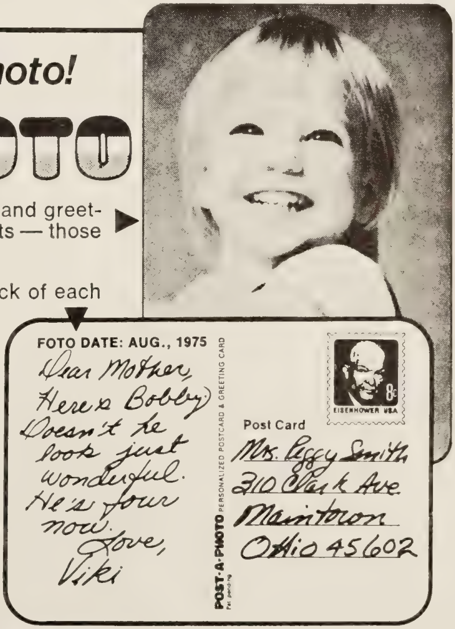

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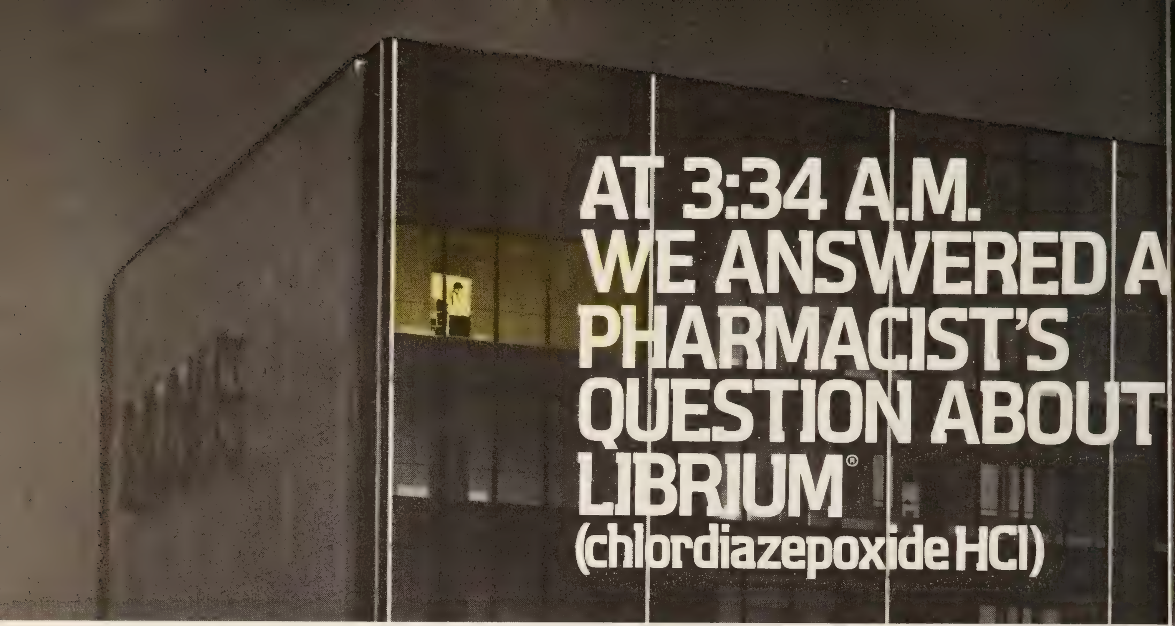

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination

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THE ANXIETY-SPECIFIC

herapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precauions in presence of impaired renal or hepatic unction. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperacive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal endencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy

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Gantrisin®
sulfisoxazole/Roche

**Before prescribing, please consult com-
plete product information, a summary of
which follows:**

Indications: Nonobstructed urinary tract in-
fections (mainly cystitis, pyelitis, pyelone-
phritis) due to susceptible organisms (usua
E. coli, Klebsiella-Aerobacter, Staph. aureus
P. mirabilis, P. vulgaris). **IMPORTANT NOT**
***In vitro* sensitivity tests not always reliab
must be coordinated with bacteriological
and clinical response. Add aminobenzoi
acid to follow-up culture media. Increasi
frequency of resistant organisms limits
usefulness of antibacterial agents, espe-
cially in chronic and recurrent urinary in-
fections.** Maximum safe total sulfonamide
blood level, 20 mg/100 ml; measure levels
as variations may occur.

Contraindications: Hypersensitivity to sulf
amides; infants less than 2 months of age;
pregnancy at term and during the nursing
period.

Warnings: Safety in pregnancy not estab-
lished. Do not use for Group A beta-hemoly
streptococcal infections, as sequelae
(rheumatic fever, glomerulonephritis) are n
prevented. Deaths reported from hypersen-
sitivity reactions, agranulocytosis, aplastic
anemia and other blood dyscrasias. Sore
throat, fever, pallor, purpura or jaundice m
be early indications of serious blood disor-
ders. CBC and urinalysis with careful micro
scopic examination should be performed f
quently.

Precautions: Use cautiously in patients wi
impaired renal or hepatic function, severe
lergy or bronchial asthma. Hemolysis, fre-
quently dose-related, may occur in glucose
6-phosphate dehydrogenase-deficient pa-
tients. Maintain adequate fluid intake to pre
vent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:*
Agranulocytosis, aplastic anemia, thrombo
cytopenia, leukopenia, hemolytic anemia,
purpura, hypoprothrombinemia and
methemoglobinemia; *Allergic reactions:*
Erythema multiforme (Stevens-Johnson sy
drome), generalized skin eruptions, epider
necrolysis, urticaria, serum sickness, pruri
exfoliative dermatitis, anaphylactoid reacti
periorbital edema, conjunctival and scleral
jection, photosensitization, arthralgia and
lergic myocarditis; *Gastrointestinal reactio*
Nausea, emesis, abdominal pains, hepatit
diarrhea, anorexia, pancreatitis and stoma
C.N.S. reactions: Headache, peripheral ne
tis, mental depression, convulsions, ataxia
hallucinations, tinnitus, vertigo and insomn
Miscellaneous reactions: Drug fever, chills
and toxic nephrosis with oliguria and anur
Periarteritis nodosa and L.E. phenomenon
have occurred. Due to certain chemical si
larities with some goitrogens, diuretics
(acetazolamide, thiazides) and oral hypog
cemic agents, sulfonamides have caused
instances of goiter production, diuresis an
hypoglycemia as well as thyroid maligna
in rats following long-term administration.
Cross-sensitivity with these agents may ex

Supplied: Gantrisin (sulfisoxazole) 0.5 Gm
tablets.

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Remember, too, that information on Gantrisin and all other Roche products is always available to you. The Roche Medical Emergency Line provides a direct, around-the-clock telephone service that can give you immediate answers to your questions. Our information specialists will answer by mail inquiries of lesser urgency. And, as you know, your Roche representative is always ready to serve you.

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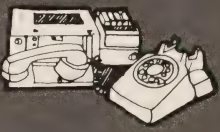

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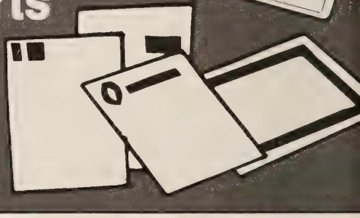

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Drug Product Selection — Another Chance

– An Editorial

Third Party Reference Chart

Maryland Poison Information Center Synopsis of 1976 Annual Report

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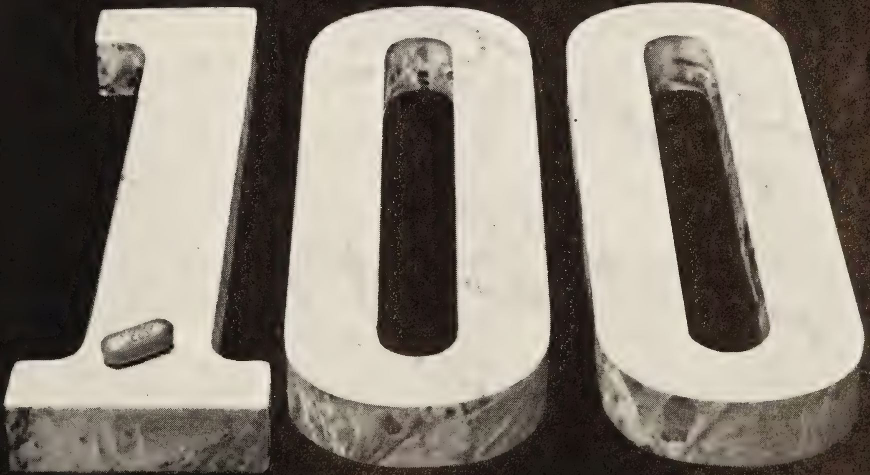
contains no aspirin

tablets
Darvocet-N® 100
100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

700184

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

When is a side effect a sign of effectiveness

With Brethine, it is when the highly effective action of the drug affects skeletal muscle as well as bronchial smooth muscle, causing tremor in some patients.

It is important for you, the pharmacist, to realize that Brethine is a β_2-adrenergic agonist. The result of this action will be highly effective bronchodilation (β_2 receptors in bronchial smooth muscle) and, sometimes, tremor (β_2 receptors in skeletal muscle of particularly sensitive patients).

If you are asked about tremor, you should be aware that tremor usually temporary, that it is a sig that Brethine is working and that easier breathing will continue ev after the tremor subsides (usually in a week or two).

Patients should follow a bedtime, morning, and midafternoon dosage schedule to avoid overlappin dosage. They should minimize their intake of coffee and other caffeinated beverages and see their physician.

BRETHINE®
terbutaline sulfate

Brethine® brand of terbutaline sulfate
Tablets 5 mg., Tablets 2.5 mg. *Before prescribing or administering, please consult complete product information, a summary of which follows:*

Tablets contain 5 mg. (equivalent to 4.1 mg. of free base) or 2.5 mg. (equivalent to 2.05 mg. of free base) of Brethine, brand of terbutaline sulfate.

Indications: As a bronchodilator for bronchial asthma and for reversible bronchospasm which may occur in association with bronchitis and emphysema.

Contraindications: Known hypersensitivity to sympathomimetic amines.

Warnings: *Usage in Pregnancy:* The safety of the use of Brethine, brand of terbutaline sulfate, in human pregnancy has not been established. The use of the drug in pregnancy, lactation, or women of childbearing potential requires that the expected therapeutic benefit of the drug be weighed against its possible hazards to the mother or child.

Usage in Pediatrics: Brethine, brand of terbutaline sulfate, tablets are not presently recommended for children below the age of twelve years due to insufficient clinical data in this pediatric group.

Precautions: Brethine, brand of terbutaline sulfate, should be used with caution in patients with diabetes, hypertension, and hyperthyroidism. As with other sympathomimetic bronchodilator agents, Brethine, brand of terbutaline sulfate, should be administered cautiously to cardiac patients, especial those with associated arrhythmias. Although the con comitant use of Brethine, brand of terbutaline sulfat with other sympathomimetic agents is not recommended, the use of an aerosol bronchodilator of the adrenergic stimulant type for the relief of an acute bronchospasm is not precluded in patients receiving chronic oral Brethine, brand of terbutaline sulfate, therapy.

Adverse Reactions: Commonly observed side effects include nervousness and tremor. Other reported reactions include headache, increased heart rate, palpitations, drowsiness, nausea, vomiting, and sweating. These reactions are generally transient in

eigy

ons, usually do not require treatment, and appear
iminish in frequency with continued therapy. In
eral, all the side effects observed are characteristic
ose commonly seen with sympathomimetic amines.
How Supplied: Round, scored, white tablets of
g. in bottles of 100 and 1000 and Unit Dose Pack-
s of 100; oval, scored, white tablets of 2.5 mg. in
les of 100
35-146-050-E (Rev. 4/76)607004 C76-12

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Drug Product Selection — Another Chance

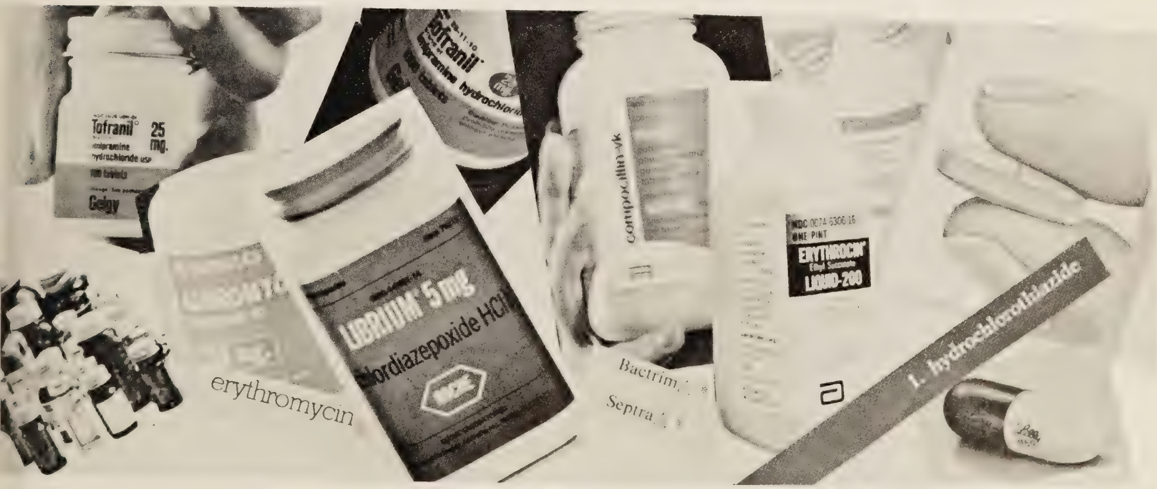
The question of drug product selection has been bandied about among consumer groups and legislators, legal counsel and administrators. There is presently a strong current of support for measures allowing the pharmacist to choose the drug entity called for by prescription. Consumer strength in our society draws the lines of battle to some degree. Those who are under public scrutiny are hard pressed to oppose a measure that will save money for the electorate. Mom and apple pie are presently assuming unusual garb.

The same question presented to pharmacists does not bring a similar voice of approval. Many are concerned that "newly acquired" freedom of choice will result in increased liability. The added responsibility may, in turn, haunt the pharmacist in a court of law when he or she explains why one product was chosen over another. Unfortunately for these opponents of drug product selection, the fear of legal repercussions clouds the fact that the pharmacist's "newly acquired" freedom of choice is nothing new at all. On the contrary, pharmacists have been and will continue to decide which company's drug product should be dispensed on prescription order. This professional right to choose is exercised whenever a prescription calls for phenobarbital, prednisone, penicillin, erythromycin, tetracycline, digoxin, hydrocortisone cream and others. In this respect, the pharmacist has already assumed the right and concommitant responsibility of drug product selection.

What is most disturbing about this topic and pharmacists' reactions to it is that a deeper, more involved concept is at stake, yet discussion persistently revolves about money saved and court costs incurred. We are dealing with pharmacy again being recognized as a creative profession. Since the advent of automated drug production, pharmacy has been relegated to a "reactive" position. To the patient, the pharmacist did nothing more than react to the prescription order and its directions. He or she responded rather than initiated action. Ours was to comply, and the public viewed pharmacists and pharmacy in that light. Now, however, appears the opportunity to alter the public's image of the pharmacist. We can impact more on his health and well being because, through our professional expertise, we will have chosen the product which is consumed. Through an active decision-making process, we have determined that the product dispensed is the best one for the patient, considering quality and cost to that patient. We will be viewed more in a professional vein rather than simply operating for a mercantile interest.

Over the past several years schools of pharmacy and professional associations have rigorously prepared recent graduates and established practitioners for these roles of active intervention in patient care. The general public is now more attuned to both the qualifications and capabilities of today's pharmacist. We can not afford to let this opportunity slip by us.

– Richard M. Schulz



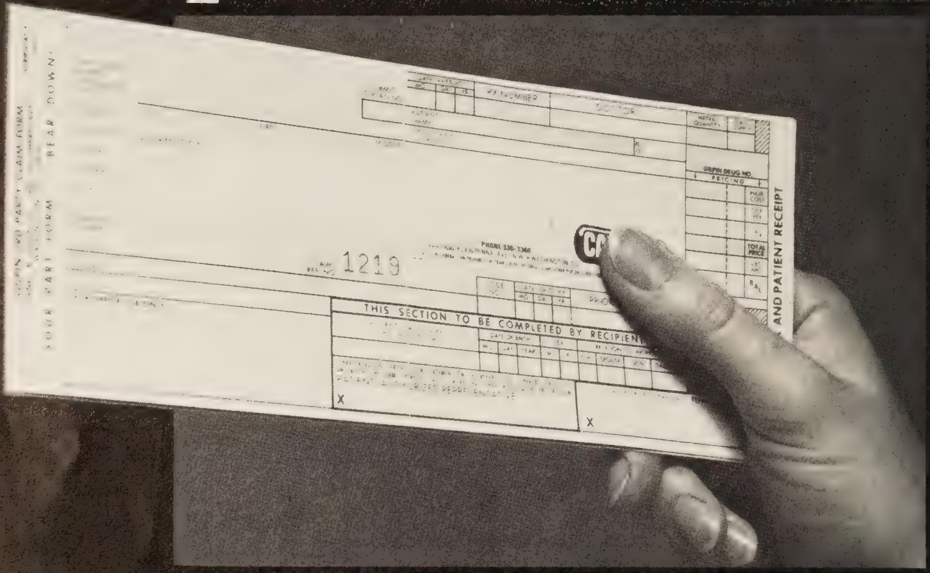
Maryland Pharmaceutical Associatio

PLAN	COST	PROF FEE	Rx BY LAW FED./STATE/LOC.	DAY/DOLLAR LIMIT
Associated Prescription Services 305 W. Monument Street Baltimore, MD 21201 539-0325 Pharmacy I.D. Number *Fund Number* 1, 2, 3, 4, 5, 6, 7, 25, 26, 34, 36, 37, 38, 50, 63, 71, 86, 285	ACQ·	$2.00 on Rx $2.00 + $1.25 for compounded Rx containing ⅜ or more ingredients	Yes/Yes/Yes	Funds *50:* Up to 34 days only *5, 34, 86:* 34 days; see exceptio list. 38,63: Greater of 34 days/100 doses *Others:* 100 days supply. If cost of ingredient $15.00 or more, 14 days supply ma mum. *Refer to maintenance list for exceptions.
Aetna Life & Casualty Group Data Processing Pharmacy Claim Unit 151 Farmington Avenue Hartford, Conn. 06115 Pharmacy I.D. Number ____	ACQ	$2.25	Yes/No/No Covers state law if "List 2" or "List 3" on card.	34 days supply. *Refer to maintenance list for exceptions.
Blue Cross, Inc. 700 E. Joppa Road Towson, MD 21204 Pharmacy I.D. Number ____ Standard/Motors Mr. Bockstie 494-5054 Mr. Housman 494-5474 Mr. Gray 494-5397	ACQ	$2.10	*Standard:* Yes/Yes/Yes *Motors:* Yes/No/No	34 days supply. *Refer to maintenance list for exceptions.
Esskay c/o MPhA, 650 W. Lombard St. Baltimore, MD 21201 — 727-0746 Pharmacy I.D. Number ____	AWP	$1.95	Yes/Yes/Yes	No defined limits.
Group Services Corporation Construction Workers Trust Fund Warehouse Employees 570 Cement Masons 43 2219 St. Paul St. Baltimore, MD 21218 — 235-0867 Pharmacy I.D. Number ___	AWP	$2.00 on Rx $2.00 + $1.00 for compounded Rx	Yes/Yes/Yes	30 days supply; 90 day limit chronic illness — unspecified
Iron Workers #16 6229 N. Charles Street Baltimore, MD 21212 — 377-6010 Pharmacy I.D. Number	AWP	$2.00	Yes/Yes/Yes	Greater of 34 days or 100 unit doses.
Medicaid Medical Assistance Oper. Adm., State Dept. Health & Mental Hygiene, P.O. Box 1935, Baltimore, MD 21203 — 383-2658 Pharmacy I.D. Number Local Telephone Numbers:	Usual and customary price only		Yes/Yes/No	100 days maximum including pr specified refill. Preauthorization needed for Rx whose ingredient cost is greater than $20 — Med^3
Medimet Metropolitan Life Insurance Co. Medimet Office Box 57 Utica, New York 13503 1-315-797-5405 Pharmacy I.D. Number a)General Motors b) Carborundum c)Firestone d)Goodyear e)Hecht Co. f)Uniroyal	ACQ	$2.15	*a,e* Yes/No/No *others* Yes/Yes/Yes	*a,e* 34 days supply; *Refer to maintenance list for exceptions. *others:* 100 days supply

Third Party Reference Chart

B.C.	OTC	REFILLS	INSULIN	MISCELLANEOUS
Plan es: 1,2,3,4,6, 36,37,285 o: 5,7,25,26, 34,38,50, 63-70,71,86 .CQ + 50%	*APS¹ Plan Yes: 1,2,3,4,6, 25,26,36,285 Specified List in Pharmacy Manual No: 5,7,34,37,38, 50,63-70,71,86	1 year	Yes Cost + 50%	*Plan* Injectables: 1,63 — Yes Others — Rx only Syringe, needles: No *Dependents:* Plan 7: up to age 21 Plan 71: spouse only Plan 5,6,34,63,86,285: up to age 23 if full time student Others: to age 21
lo — Unless C" on card	Non-inj. Adrenalin Aveeno Acetaminophen N.F. Acidolate If card specifies "List "1" or "List 3"	1 year	Yes — Fee	Injectable — Rx only Diaphragm — No Syringe — No Therapeutic Devices — No
lo	No	1 year	Yes — up to 4 vials U & C	Injectable — Rx only Diaphragm — No Syringe — No
No	No	Per M.D.	Yes — Fee	Injectable — Rx only Diaphragm — No Syringe — No
No	No	1 year	Yes Cost + 50%	Injectable — Rx only Diaphragm — No Syringe — No
No	No	5	Yes — Fee	Injectable — Rx only Diaphragm — No Syringe — No Appliances — No
Yes	No	2 within 100 days if on original Rx. 6 month supply allowed for B.C.	Yes, if on Rx	Medical Supplies — *Med — 1 Injectable — Yes, for self-administration Diaphragms — Yes Needles & Syringes — Yes *Med — 2 Permanent Urinary Incontinent supplies excluding pads and rubber sheet — yes
No	No	1 year	Yes — Fee	Injectable — Rx only Syringe/Needles — No Diaphragm — No

Here's the only third-party claim form you'll ever need.



Introducing Scrip Stat, the third-party claim form that reduces a moutain of paperwork to a few simple lines.

Scrip Stat works as part of a complete computer program that makes processing any third-party claim—from Medicaid to union insurance—quick and easy. And it's specifically designed to reduce expensive errors and costly form rejections.

The Scrip Stat system eliminates unnecessary duplication. You're completing the prescription label at the same time you're completing the third-party claim. You're also making the store's accounting copy and the patient profile.

All automatically. All at the same time.

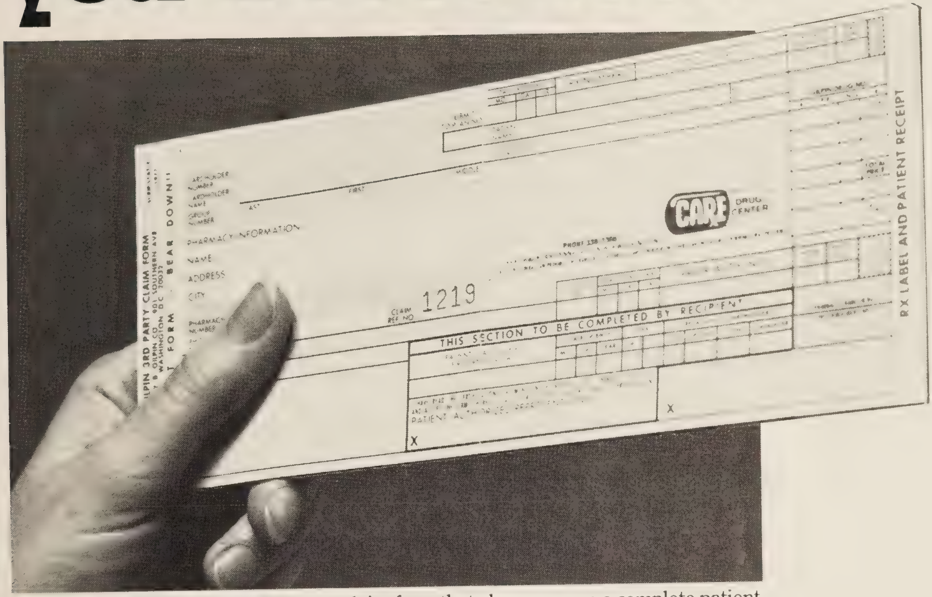
Scrip Stat submits your claims via computer. And, most important, it will help get your third-party payments on time.

Some experts predict that 60% of all prescriptions will be paid for by third parties within three years. If you don't have Scrip Stat, the paperwork will continue to stack up—and your cash flow will continue to slow down.

So Scrip Stat will make your life easier and your business more profitable.

And that's just the half of it.

Here's the only Patient Profile form you'll ever need.


GILPIN 3RD PARTY CLAIM FORM
PHARMACY INFORMATION
NAME
ADDRESS
CITY
CARE DRUG CENTER
CLAIM REF NO
1219
THIS SECTION TO BE COMPLETED BY RECIPIENT
PATIENT AUTHORIZED
X
X
RX LABEL AND PATIENT RECEIPT

Introducing Scrip Stat, the third-party claim form that also serves as a complete patient profile system.

Every time you complete the Scrip Stat form, you're adding to your individual patient records.

In seconds, you can check the profile for allergies, over and under use, drug interactions, dosages and additional factors calling for special warnings or instructions.

With Scrip Stat you can make sure your customer's getting a prescription that's right for him. It's a service to the patient, a back-up check for the physician, and a marketing tool for you. (After all, any customer who knows what's good for him will keep coming back to you for *all* his prescriptions.)

Scrip Stat speeds up collections, cuts down on paperwork, and helps take the pharmacist from behind a desk and put him behind the counter. It can also reduce the need for extra manpower and extra overtime.

That's the good news. The bad news is that the Scrip Stat Claim Service isn't available in every state. Yet.

But Gilpin is working on it. We're out to become the nation's most valuable wholesaler. We're going to do it by helping you make your store or stores more profitable. If it takes new systems, we'll develop them.

And we'll probably do it first.

To find out more, call Bill Burke, R.P., collect at (301) 630-4500. Or simply mail the coupon.

SCRIP STAT.
FROM THE HENRY B. GILPIN COMPANY.

THE HENRY B.
GILPIN
COMPANY
901 Southern Avenue
Washington, D.C. 20032 Phone (301) 630-4500
Attn: Bill Burke, R.P.

Tell me more about Scrip Stat and how it can help me reduce my overhead while increasing my profits.

Name________________________

Phone________________________

Firm ________________________

Address________________________

City__________State_______Zip_____

C 1

Third Party Reference Chart

PLAN	COST	PROF FEE	Rx BY LAW FED./STATE/LOC.	DAY/DOLLAR LIMIT
National Benefit Fund 310 W. 43rd Street New York, N.Y. 10036 1-217-582-1890 Pharmacy I.D. Number ________	AWP	$2.00 $2.00 + $1.00 for compounded Rx	Yes/Yes/No	10 days supply except up to 3 days if maintenance drug on li or chronic condition is indicat
PAID Prescriptions, Inc. P.O. Box 434 Paramus, N.J. 07652 1-800-631-1679 a Acme 5 b Bakery 4 c Carpenter 4 d Electrical 4 e PPG 2A f Pressman 4 g Provident 5 h TWUA 4 i United Parcel 7 j Wilmington 4 k Worthington 2A l Hochschild Kohn 5	ACQ: 2a AWP: Others	Group I/Group II *a,c,f,h,j:* $1.85/$2.10 *b,d,g,i:* $2.00/$2.25 *e:* $2.15/$2.15 *k:* $2.25/$2.25	*2a* Yes/No/No *others:* Yes/Yes/Yes	*2a:* 34 days supply *Refer to maintenance list *others:* greater of 34 days or 100 doses
Pharmaceutical Card System (PCS) P.O. Box 20831 Phoenix, Arizona 85036 1-602-257-1500 Pharmacy I.D. Number ________ 20 91 112 152 22 94 115 166 31 104 121 195 83 105 137 252	20,83,115,121, 137 ACQ *others* AWP	22,104,105 - $2.00 20,166,152 - $2.05 137,152 - $2.10 83,121 - $2.15 112,195 - $2.20 31,91,94, 105 - $2.25	104,105,115,121, 152,195,252 Yes/Yes/Yes *others* Yes/No/No	31,137 — no limit 104,105 — greater of 34 days o 100 do 115 — 100 days 91,94 — 34 days supply *See exception list. 40 doses antibiotics 4 oz. cream or oint. others: 34 days *See exception list.
Pharmaceutical Services Foundation (PSF) 6801 Quad Avenue Baltimore, MD 21237 — 866-4059 Pharmacy I.D. Number ________	AWP	$2.10	Yes/Yes/No	Greater of 34 days or 100 doses
Prescription Drugs, Inc. (PDI) 9008 Red Branch Road Oakland Ridge Industrial Park Columbia, MD 21045 — 997-3550 Pharmacy I.D. Number ________	AWP	$1.95	Yes/Yes/Yes	Greater of 34 days or 100 doses
Travelers Insurance Company 111-4 Thomaston Avenue Waterbury, Conn. 06708 1-203-277-0111 Pharmacy I.D. Number ________	Plan 1: ACQ Plan 2: AWP	$2.25	Yes/No/No	34 days supply

GENERAL NOTES

34 days/100 doses	=	*Greater of* unless otherwise indicated.
U + C	=	Usual and Customary Selling Price; on insulin this should not exceed cost + 50%
BC	=	Birth Control
OTC	=	Medication not requiring a prescription by federal, state, or local laws
Cmpd. Rx	=	At least one of the ingredients must require a prescription; compounding includes more than simple mixing of liquids or reconstitution of powder

The Third Party Reference Chart is being repeated from the June Newsletter to provide members of the Association two methods of obtaining the needed information.

B.C.	OTC	REFILLS	INSULIN	MISCELLANEOUS
ys	No	5 within 6 month period	Yes — Fee	Injectable — Rx only Diaphragm — No Syringe — No
Yes up to 3 months ers: no	No	per M.D.	Yes U & C	Injectable — Rx only Diaphragm — No Needles & syringes — 7: yes others: no
5 – yes, oral or otherwise *hers* – No	*104* – Adrenalin Aveeno Acetaminophen N.F. Acidolate *166* – Sugar test tape or tablets, acetone test tablets. Benedicts sol. or equiv., syringes & needles (2)	per M.D. up to one year	*Yes* *83,105,166,252* Rx not needed *Others* Rx required All: Cost + 50%	137 — Sugar test tape or tablets, acetone test tablets, Benedicts sol, or equiv. syringes & needles (2) — all by Rx only. *Others* Injectable — Rx only Diaphragm — No, 195 yes Syringe — No, 166 yes, 137 yes on Rx Needles — No, 166 yes, 137 yes on Rx
o	No	5 maximum	Yes — cost + 50%	Injectable — Rx only Diaphragm — No Syringe — No
dicated on dividual card	No	per M.D.	Yes — cost + 50%	injectable — Rx only Diaphragm — No Syringe — No
es — Fee	No	1 year	Yes — Fee	

SPECIFIC NOTES

APS¹ — OTC approved list found in each pharmacy's manual

Blue Cross Mack truck ID cards have group numbers K214, K258, K701, K702, K703, K704 or K709.
Baltimore City Employees (card P-900 series) entitled to 100 days supply of maintenance drugs
Pay for dependents up to Dec. 31st of last year of eligibility
Date on card is issue date, not expiration date

Medicaid – Med¹ — Medical supplies covered with retail $10 or less
Medical supplies exceeding $10 retail covered under Medical Supply Program
Additional form required
Med² — Cost of needles and syringes must be less than $10 — if over $10, covered by Medical Supply Program.
Med³ — Preauthorization needed if ingredient cost exceeds $20 (to allow for price increases, suggest getting preauthorization if cost exceeds $18) . . . call local subdivision

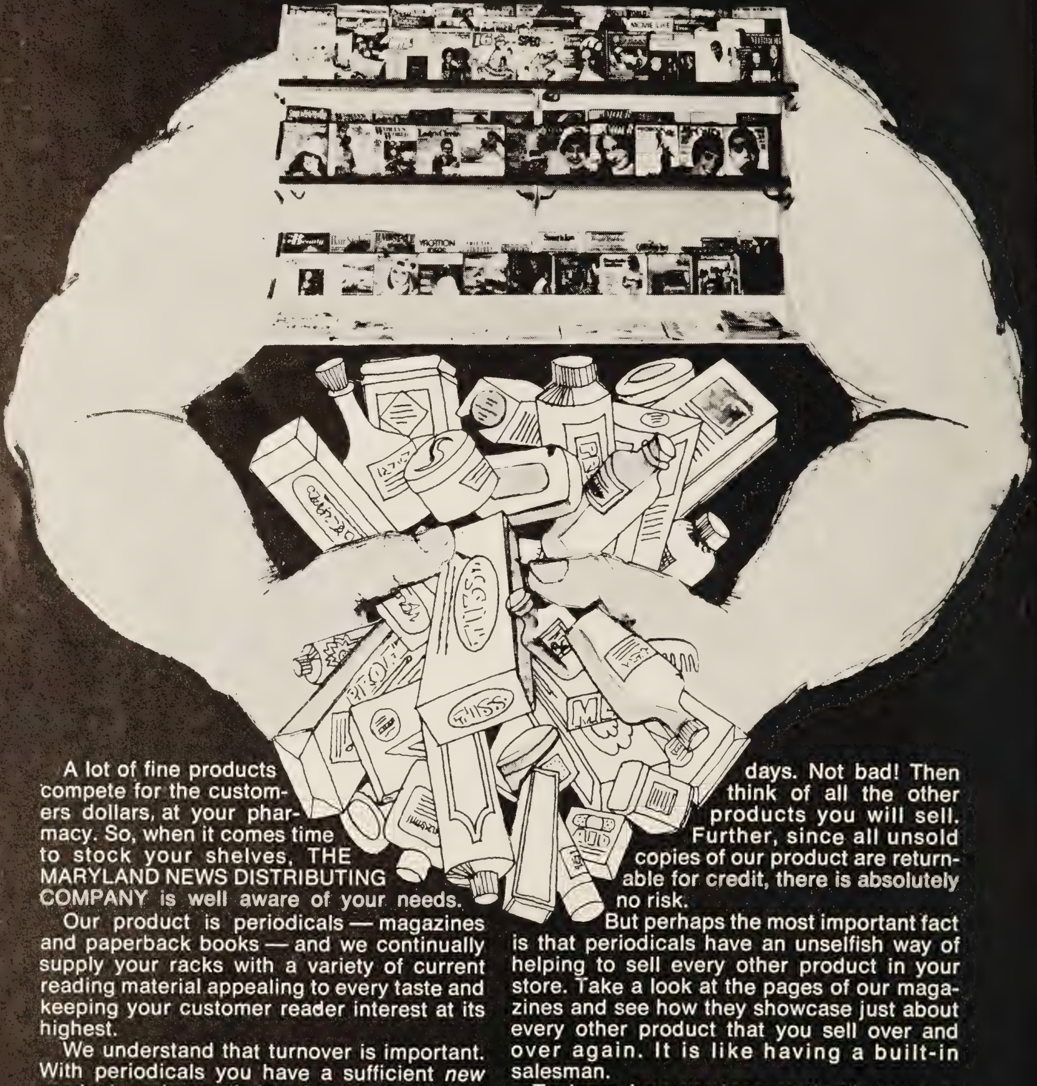
NDC Numbers (Assigned)

Needles & syringes less than $10	— 996-1111-00
Catheters — $10	— 996-2222-00
Compounded Rx	— 998-0000-00
Rx only, no NDC number	— 999-0000-00
Any other approved supply less than $10	— 996-0000-00

Phone Numbers — Policy: 383-2658
Prices/Returned Invoices: 383-2955
Payment Errors: 383-6481

Continued on page 20

Help Yourshelf...



A lot of fine products compete for the customers dollars, at your pharmacy. So, when it comes time to stock your shelves, THE MARYLAND NEWS DISTRIBUTING COMPANY is well aware of your needs.

Our product is periodicals — magazines and paperback books — and we continually supply your racks with a variety of current reading material appealing to every taste and keeping your customer reader interest at its highest.

We understand that turnover is important. With periodicals you have a sufficient *new* product each month to stimulate traffic not only for our product, but for *all* the products in your store.

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Ask about periodicals, the unselfish product.

FREE SAMPLE.

Convince yourself...before you convince your customers.

Zincon
dandruff shampoo
CLINICALLY PROVEN
leaves hair clean & easy to manage
Net 8 fl. oz.
DI

- No selenium, sulfides, tar, resorcinol, free sulfur or salicylic acid.
- Active ingredient Pyrithione Zinc (1%).
- Double-blind tests with "severe dandruff" cases demonstrated a reduction in dandruff flakes in about 80% of the cases.* (And no shampoo was superior.)

- Does not cause dry or oily hair.
- Can be used on tinted or natural colors including gray.
- Contains finest hair conditioners: leaves hair clean and easy to manage.

Lederle

LEDERLE LABORATORIES,
A Division of American Cyanamid
Company, Pearl River,
New York 10965

If you are interested in giving ZINCON® Dandruff Shampoo a trial, at our expense, send in a written request on your store stationery and we will forward one 4 oz. bottle to you.

Forward your request to the following address:

LEDERLE LABORATORIES
P.O. Box 171
Fairview, New Jersey 07022

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* Data on file, Lederle Laboratories

063-7

Announcing the Pharmacis

☐ A valuable review of antibiotic therapy for hospital, community and nursing home pharmacists

☐ Devoted to the specific information needs of pharmacists in today's health care environment

☐ Accredited for continuing education in many states

PATT: an important contribution to continuing education for pharmacists

The Pharmacist Antibiotic Therapy Test (PATT)—a full-color, self-assessment learni system on videotape—provides a comprehensive review of current concepts in infectious disease therapy relevant to the varying roles today's pharmacist.

The PATT presents simulated clinical, community, hospital and nursing home case studies to demonstrate the pharmacist's important place on the modern health care tea All questions, answers and clinical situations are based on accepted treatment methods an a thorough review of the literature. The pane ists, selected from a variety of different academic and professional backgrounds, represe an interdisciplinary approach to health care.

For information on how to arrange a *group* showing, contact your Roche representative or the Professional Services Departme Roche Laboratories, Nutley, New Jersey 0711

Antibiotic Therapy Test

LAROTID® (amoxicillin): an important contribution to broad spectrum antibiotic therapy

Virtually complete absorption

Over 90% of an oral dose of Larotid (amoxicillin) is absorbed, even with food. At best, only 50% of oral ampicillin is absorbed on an empty stomach.

Excellent clinical results

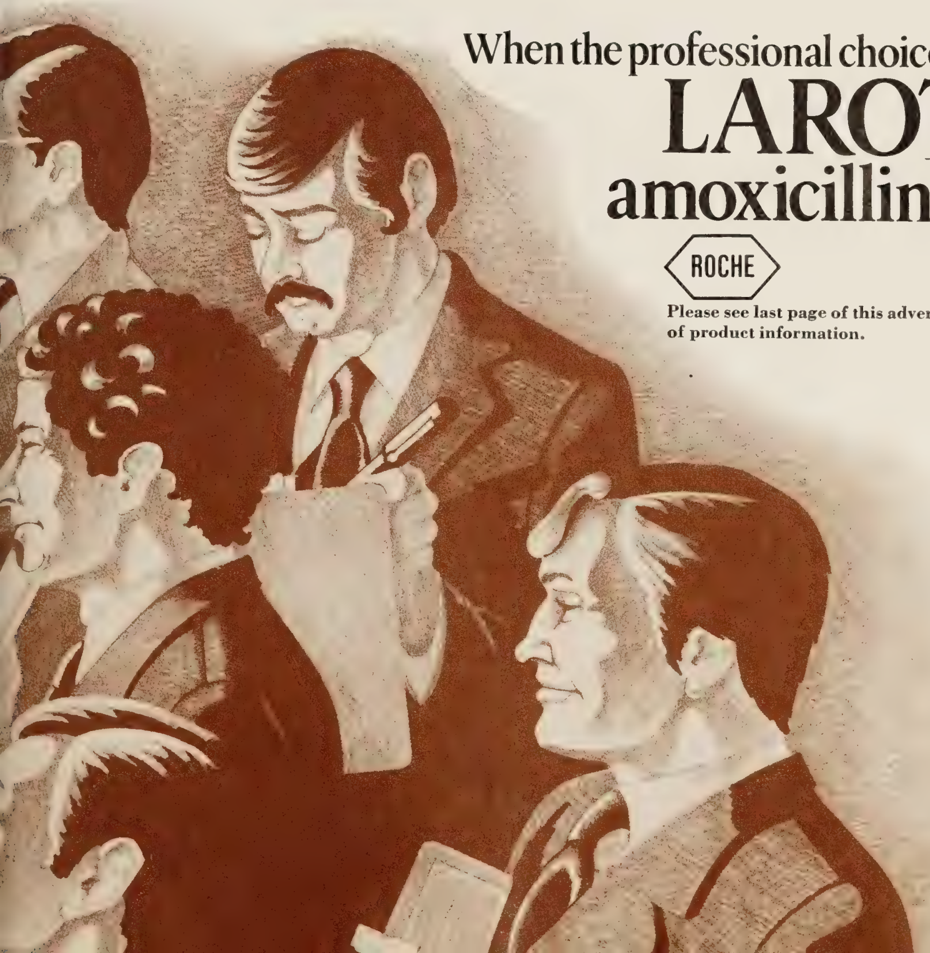
Larotid has demonstrated excellent clinical efficacy in many of the infections doctors see most often, including infections of the respiratory and urinary tracts due to susceptible bacteria. It should not be given to anyone allergic to penicillin.

Fast turnover from the most widely prescribed brand

Your inventory turns over faster when you fill *all* amoxicillin scripts with Larotid. There's no need to stock any other.

Liberal Roche return goods policy

Roche Laboratories will reimburse pharmacists for all Roche products which may be outdated or discontinued—helping you maintain an active, profitable inventory.



When the professional choice is yours...

LAROTID®

amoxicillin/Roche

ROCHE

Please see last page of this advertisement for a summary of product information.

When the professional choice is yours...

LAROTID®

Capsules 250 mg
and 500 mg
Pediatric drops
Oral suspension

amoxicillin/Roche

the most widely prescribed amoxicillin

Please consult complete product information, a summary of which follows:

Indications: Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae, E. coli, P. mirabilis* and *N. gonorrhoeae;* and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and nonpenicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. **SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.**

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy, asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. *NOTE:* Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: Ear, nose, throat, genitourinary tract, skin and soft tissue infections—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. Lower respiratory tract infections and severe infections or those caused by less susceptible organisms—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. Gonorrhea (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. NOTE: Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

Supplied: Amoxicillin as the trihydrate: Capsules, 250 mg and 500 mg; oral suspension, 125 mg/5 ml and 250 mg/5 ml; pediatric drops, 50 mg/ml.

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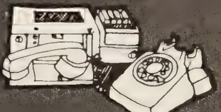

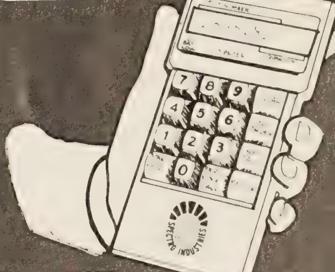

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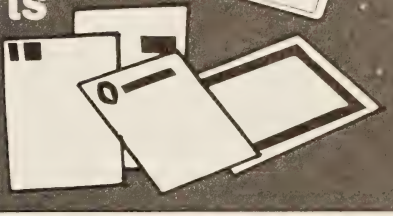

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- Quarterly Label Color Change.
- Tamper-proof (non-transfer) security.
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A = 100 days maximum
B = Greater of 34 days/100 unit doses maximum
C = Greater of 34 days/200 unit doses maximum
D = 100 doses maximum
E = 200 doses maximum

	DRUGS	APS	AETNA	BLUE CROSS MT = Mack Truck Only		NATIONAL
A	Acetazolamide	A	D	B	B	
	Acetohexamide	A	D	B	B	
	Aldactazide					B
	Aldomet					B
	Aldoril					B
	Allopurinol	A	D	B	B	
	Apresoline					B
	Arlidin					B
	Atromid S					B
	Azulfidine					B
B	Banthine					B
	Benadryl					B
	Benemid					B
	Benzthiamide	A	D	B	B	
C	Cardiac Glycosides		D			
	Cardilate					B
	Cari-Tabs					B
	Chlortrimeton					B
	Chlorothiazide	A	D	B	B	
	Chlorpropamide	A	D	B	B	
	Colbenemid					B
	Colchicine	A	D	B	B	B
	Colchicine+Probenecid	A	D	B	B	
	Conjugated Estrogens	A	D	B	B	
	Cytomel					B
D	DBI; DBI-TD					B
	Diabenese					B
	Diamox					B
	Dicumarol					B
	Digitalis Leaf	A		B	B	B
	Digitoxin	A		B	B	B
	Digoxin	A		B	B	B
	Diphenylhydantoin Sod.	A	E	B; C-MT	C	B
	Dimetane					B
	Diupress					B
	Diuril					B
	Donnatal					B
	Dymelor					B
E	Esidrix					B
	Exna					B
F	Fulvicin					B
G	Gitalin	A		B	B	
	Grifulvin					B
	Griseofulvin					B
	Grisactin					B
H	Hydrochlorthiazide	A	D	B	B	
	Hydrodiuril					B
	Hydropress					B
I	Inderal					B
	Ismelin					B
	Isoniazide	A	E	B;C-MT	C	
	Isordil					B

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If the generic drug is checked, any brand may be dispensed
If the brand name is checked, only it may be dispensed

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MEDIMET Gen. Mtrs./Hecht Co.		PPG/Worthington Pump		152	20,22,121,166	83,112	91,94,195
B	B		B	B	B		
B	B	B	B				
B	B		B				
B	B		B				
B	B	B	B	B	B		
B	B	B	B	B	B		
B	B	B	B	B	B		
B	B	B	B	B	B		
B	B		B				
							B
							B
B	B	B	B	B	B	B	
B	B	B	B	B	B	B	
B	B	B	B	B	B	B	
C	B	B	B	•B	B		
							B
B	B	B	B				
B	B	B	B	B	B		
C	B		B				

(Continued on page 30)

Maryland Poison Information Center

Synopsis of 1976 Annual Report

by

Gary M. Oderda, Pharm.D.*

Jacquelyn S. Lucy, M.A., M.Ed.

Description of Services

The Maryland Poison Information Center (MPIC) provides emergency treatment information regarding potentially harmful items to residents of the State of Maryland. The Center as it exists today was begun in 1971 when the Maryland Poison Information Center located at Baltimore City Hospitals merged with the poison center at the University of Maryland Hospital. A division of the University of Maryland School of Pharmacy, the MPIC operates 24 hours a day seven days a week providing information by telephone to both health professionals and the general public. Acting as an information and referral service, the MPIC determines the severity of the situation and recommends specific treatment. When any patient requires treatment outside the home, he is routinely referred to his private physician or local emergency room. As a specialty referral center of the Emergency Medical Resources Center (EMRC), the MPIC can communicate directly with ambulances en route to emergency rooms and arrange conference calls with consultants and emergency room personnel.

Statistical Data

During 1976, the Center received a total of 22,676 calls, thus exceeding 20,000 calls for the first time in its history. Of these calls, the MPIC classified 18,020 as ingestions and 4,656 as inquiries. All calls involving *human exposure* to a substance — toxic or non-toxic — by any route (oral, topical, rectal, etc.) are classified as *ingestions*. *All other calls* are considered *inquiries*.

While the Center is available to all residents of the State of Maryland, the majority of calls continue to come from the Baltimore metropolitan area. In fact, 87.9% came in on our Baltimore phone line, (301) 528-7701. The remaining 12.1% were received on our WATS line (1-800-492-2414) which serves those areas outside the local Baltimore metropolitan area and represented an increase from 7.0% in 1975.

As compared with 1975, total calls increased by 31.7%, ingestions by 28.0% and inquiries by 48.4%. The following chart summarizes calls by year from 1966-1976. The data reported from 1966-1970 is from when the Center was at Baltimore City Hospitals.

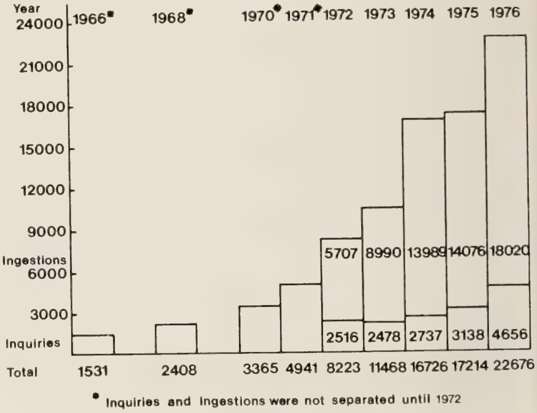


Figure 1
Calls by Year 1966-1976

From Figure 1, a steady increase in the number of calls to the Center can be noted. While some of this increase may be due to strenuous efforts to record each call, it is our feeling that much of the increase reflects a growing public awareness of the Center's existence. We feel that this increase does not signify an increased number of ingestions but rather an increase in the percentage that are being reported to the MPIC.

The majority of ingestion calls received continue to come from the general public. A total of 14,344 non professional calls were received, an increase of 31.0% over 1975. Health professional calls increased by 20.0% (from 2717 to 3262) during the same period. During 1976, 79.6% of ingestion calls were received from the general public, 2.3% from crisis intervention centers (hotlines), and 18.1% from health professionals.

Age Distribution

Ingestions by children less than five years of age continue to account for the majority of calls to the MPIC and accounted for 58% of total ingestions in 1976. The following table summarizes the percentage of ingestion calls by age group from 1966-1976.

---

* Dr. Oderda is Associate Professor, Division of Clinical Pharmacy, University of Maryland School of Pharmacy, and Director of the Maryland Poison Information Center

† Ms. Lucy is Associate Staff and Poison Information Officer at the Maryland Poison Information Center

Figure 2
Percentage of Ingestion Calls
by Age Group 1966-1976

	5	5-11	12-24	24
1966	70	4	5	21
1968	53	5	19	23
1970	55	3	21	21
1972	78	5	10	8
1973	72	6	12	11
1974	64	7	14	16
1975	56	7	14	23
1976	58	8	15	19

The age distribution for 1976 is similar to that seen in 1975. The total age range of patients in 1976 was from 1 month to 97 years.

Action Involved

Accidental ingestions continue to account for the majority of ingestions to a total percentage of 67.6 during 1976. Suicide and suicide gestures accounted for 8.5% while 3.6% were drug abuse related.

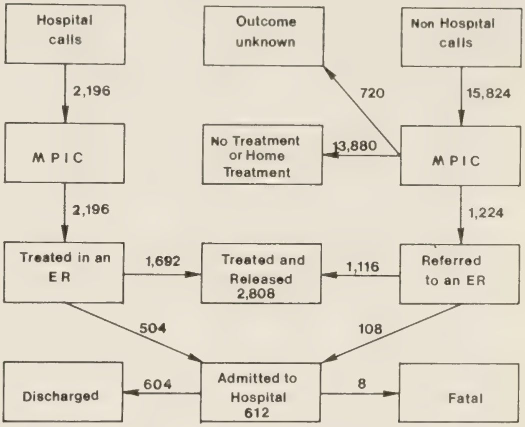
Skin contamination and eye contamination each accounted for 3.3% of the cases. Exposure by inhalation (3.4%) and by animal bites and stings (2.5%) also involved a significant number of calls. The intent was unknown in 4.5%. Other types of exposure accounted for 3.4% which included intentional exposure to therapeutic agents that produced side effects and other miscellaneous types of exposure.

As one might expect, most of the expsoures in the under 5 age group may be classified as accidental oral.

Outcome of Calls

The following figure summarizes the outcome of our calls. Those classified as hospital calls involved patients who were already being treated in a hospital setting. The non-hospital calls involve all other patients, most of whom were at a private residence when the initial call was received.

Figure 3
Outcome of Calls 1976



Continued on page 28

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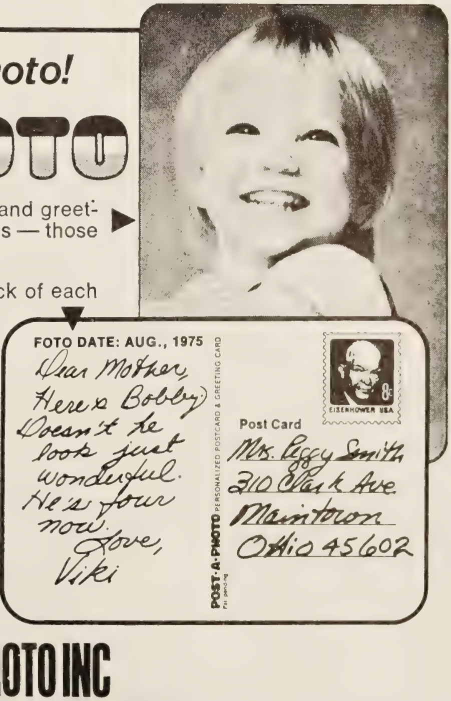

FOTO DATE: AUG., 1975
Dear Mother,
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Doesn't he
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wonderful.
He's four
now.
Love,
Viki

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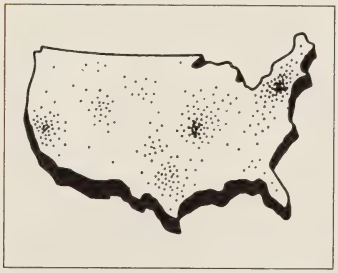

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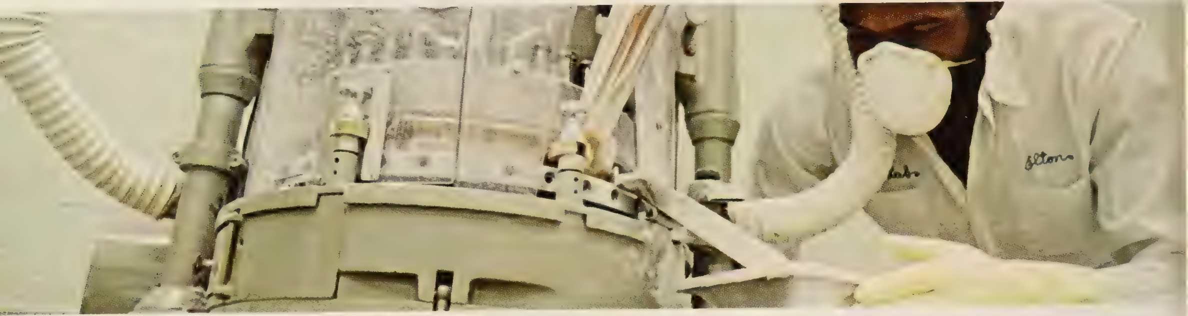

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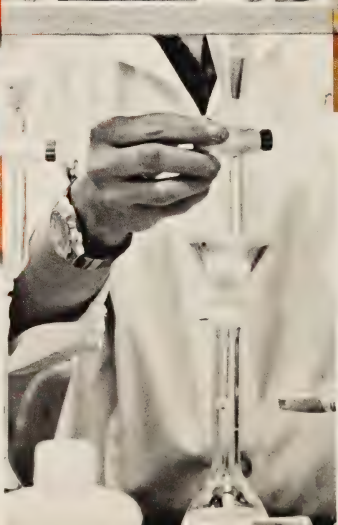

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Anthony G. Padussis Presented with Honored Alumnus Award

In ancient Greece, at the conclusion of the Olympian games, it was the custom to award the victor a crown of wild olive from the sacred olive tree. While the olive crown constituted the only official prize, the victor was also banqueted by the state at the public hall.

Tonight the Alumni Association awards its symbolic olive branch in the form of the Honored Alumnus Award to a fellow son of Greece, Anthony G. Padussis.

Tony is familiar to most of you in this room in as much as he is past president of the Baltimore Metropolitan Pharmaceutical Association, the Maryland Pharmaceutical Association, the Alumni Association and PHARMPAC. He was appointed by the Honorable William Donald Schaefer to serve on the Committee of Mental Health and Hygiene for Baltimore City. He is the recipient of the A.H. Robbins "Bowl of Hygiea" award and Chairman of the Board of Directors of Calvert Drug Company. Outside the field, he is presently serving as President of the Kiwanis Club of Parkville and is past president of St. Nicholas Greek Orthodox Church.

As is his nature, he has quietly devoted himself for many years to promoting the advancement of pharmacy through the legislative process in Annapolis for the benefit of *all* pharmacists throughout the state. This is a thankless job which reaps little acknowledgement and not enough cooperation from those of us who take neither the time nor the effort to participate. Very few know the extent of his devotion to this cause.

Doc Anthony was the founder of Edwards and Anthony Pharmacy along with the late and much loved alumnus, Eddie Passaro. A graduate of the class of '44, he has been in retail or community pharmacy ever since.

There are a number of fellow alumni of "The Edwards and Anthony School of Pharmacy" here tonight — all of whom have completed basic training under General Padussis. We may be found in just about any phase of pharmacy-community, hospital, and the like. Of course, not all Edwards and Anthony graduates have become outstanding pharmacists; some have become physicians and dentists.

To describe him best is to say that Tony Padussis is a hard working, tough, fair, and honorable man.

Anthony G. Padussis, in lieu of an olive branch, would you therefore step forward and accept the 1977 Honored Alumnus Award of the University of Maryland School of Pharmacy along with my warmest personal good wishes.

— George C. Voxakis

George C. Voxakis (left) and Anthony G. Padussis (right).

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Continued from page 23

Several points are obvious from this flow chart. First, the majority of calls to the center are not from a hospital setting. Second, of the non-hospital calls the vast majority required either no treatment or home treatment (13,880 of 15,824 or 87.7%). Treatment at home consisted primarily of such first aid techniques as washing the skin or eye or administering syrup of ipecac as an emetic. The home treatment was monitored by the Center and if further treatment was indicated, the patient was referred to his local emergency room or private physician. The outcome unknown group primarily involves patients who were attempting suicide or involved drug abuse patients who refused to give us their name or phone number and thus were lost to follow up. These callers may or may not have been given specific treatment information. Only 8.0% of non-hospital callers required treatment in an emergency room and of these fewer than 1 in 10 (108 of 1224) required admission to the hospital. As one would suspect, a higher percentage of the hospital calls required admission, 23.0%, since presumably those patients who had more severe symptoms would refer themselves into an emergency room rather than calling the MPIC.

The following table lists a breakdown of age vs. product ingested. If an individual has ingested more than one agent, each agent would be listed in this table. Thus the total, 19,670 is different from the total number of ingestions that occurred, 18,020.

AGE VS. PRODUCT INGESTED

PRODUCT INGESTED	AGE								
	<1	1-4	5-11	12-16	17-24	25-49	> 50	Unknown	Total
Aspirin	1	324	39	44	93	75	8	22	606
Other Non-Prescription Drugs	21	1098	167	149	383	381	58	105	2362
Barbiturates	1	37	4	40	114	77	10	17	300
Non-Barbiturate Sedative Hypnotic	1	11	8	16	81	120	22	30	289
Major and Minor Prescription Tranquilizers	0	138	22	100	307	468	40	82	1157
Other Prescription Drugs	25	830	165	225	657	678	120	139	2839
External Medicines	76	735	66	27	37	67	57	36	1101
Street Drugs	1	2	0	50	140	43	1	14	251
Caustics	10	143	31	16	39	90	17	29	375
Petroleum Distillates	40	577	54	46	102	138	28	31	1016
Household Products	107	1075	99	29	54	158	54	46	1622
Cosmetics	73	1127	63	12	16	34	18	11	1354
Plants	315	823	132	22	21	23	9	29	1374
Pesticides	50	428	57	14	43	95	22	47	756
Chemicals	18	362	121	75	111	204	44	80	1015
Glues & Adhesives	1	107	18	12	17	13	10	8	186
Paints	46	232	27	9	13	24	4	3	358
Veterinary Products	4	91	11	8	3	8	9	1	135
Food	24	134	85	34	83	232	39	40	671
Unknown	3	16	11	4	18	7	3	5	67
Miscellaneous	161	825	269	100	107	242	61	60	1825
TOTALS	978	9115	1449	1032	2439	3177	635	835	19,670

(Continued on page 32)

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Continued from page 21

	DRUGS	APS	AETNA	BLUE CROSS MT = Mack Truck Only Standard/Motors		NATIONAL BENEFIT
L	Lanoxin					B
	Lasix					B
	Letter					B
	Levothyroxine	A	E	B;C-MT	C	
	Liothyronine	A	E	B;C-MT	C	
	Luminal					B
	Luride Tablets					B
M	Mandelamine					B
	Meltrol					B
	Menest					B
	Methyclothiazide	A	D	B	C	
	Mysoline					B
N	Naldecon					B
	Naqua					B
	Naturetin					B
	Nitroglycerin	A	D	B	B	b
O	Orinase					B
	Ornade					B
P	P-Aminosalicylic Acid	A	E	B;C-MT	C	
	Pentaerythritol T'ntrte	A	D	B	B	
	peritrate					B
	Persantine					B
	Phenformin	A	D	B	B	B
	Phenobarbital	A				B
	Phenylbutazone	A	D	B	B	
	Polythiazide	A	D	B	B	
	Potassium Chloride Liq.		D	B	B	
	Prednisone					B
	Prednisolone					B
	Premarin					B
	Primodone	A	E	B;C-MT	B	
	Priscoline					B
	Probanthine P1 & Pb					B
	Probenecid	A	D	B	B	
	Proloid					B
	Pronestyl		D			B
	Propranolol	A		B	B	
	Pyrabenzamine					B
Q	Quadrinal					B
	Quinidine Sulfate	A	D	B	B	B
R	Raudixin					B
	Regroton					B
	Reserpine	A	D	B	B	B
S	Saluron					B
	Salutensin					B
	Ser-Ap-Es					B
	Serpasil					B
	Spiranolactone	A	D	B	B	
	Sulfisoxazole					B
	Synthroid					B
T	Teldrin					B
	Temaril					B
	Thyrar					B
	Thyroglobulin	A	E	B;C-MT	C	
	Thyroid	A	E	B;C-MT	C	B
	Thyrolar					B
	Tolazamide	A	D	B	B	
	Tolbutamide	A	D	B	B	
	Tolinase					B
	Triaminic					B
	Trichlormethiazide	A	D	B	B	
	Trinsicon					B
V	Vasodilan					B
	Vitamins — Legend					B
Z	Zyloprim					B

METROPOLITAN LIFE MEDIMET Gen. Mtrs./Hecht Co.		PAID PPG/Worthington Pump		152	PHARMACEUTICAL CARD SYSTEM 20,22,121,166	83,112	91,94,195
C	B	B	B				
C	B	B	B				
B	B		B				
B	B	B	B	B	B	B	B
							B
C	B	B	B	B	B		
B	B	B	B	B	B		
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B	B	B	B	B	B		
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C	B	B	B	B	B	B	B
B	B		B				
B	B	B	B	B	B		B
B	B		B				

Continued from page 28

Deaths

During 1976 the MPIC was involved with the follwoing patients who died:

	Age	Sex	Agent(s) involved	Action involved
1)	18	Male	Phenytoin	Suicide
2)	22	Female	Secobaribital Methaqualone	Suicide
3)	30	Male	Carbon Monoxide	Suicide
4)	31	Male	Pentobarbital Diazepam Oxycodone combination	Suicide
5)	40	Male	Methanol	Unknown
6)	52	Male	Unknown	Unknown
7)	56	Female	Imipramine	Suicide
8)	91	Male	Phenobarbital	Suicide

The number of poisoning related deaths occurring in the State of Maryland is surely larger than eight, although mortality figures for the State of Maryland have not been released by the Maryland Center for Health Statistics. In 1975, however, there were 185 poisoning related deaths in Maryland. Of these 21 were classified as accidental, 125 as suicidal and 36 as unable to determine. During 1975 the MPIC was involved with five of these deaths. The large discrepancy between total deaths and those that we are involved with may be explained in several ways. First, many of these patients are either found dead or are dead on arrival at the emergency room and thus calling the MPIC is unnecessary. The remainder of patients may involve (1) those whom we were involved with but were lost to follow up, (2) those who were treated in emergency rooms and another poison center was called, or (3) those who were treated without calling a Poison Center.

Conclusions

The statistical data just presented represents much of the experience of the Maryland Poison Information Center. Yet, during 1976, we noted many patterns which we do not presently quantitate. The continued increase in the number of total calls suggests a recognition by the lay public and health professionals of the Center's role as Maryland's central repository of information on poisonings. A growing number of referral calls from physicians' offices, emergency rooms, veterinarians and crisis centers demonstrates another positive advance. Increases in inquiries about potential poisons seem to indicate more active poison prevention activities.

Future Plans

Because the increased participation by the MPIC in community outreach programs has paralleled the increased total call rate, the Center plans to add two full-time pharmacists to our staff in July 1977. This will allow for the creation of a new position devoted to data collection, both at the MPIC and the hospital level and to public information activities including working with the media, developing teaching programs, etc. The additional pharmacist positions will also allow the Center's pharmacists to participate more directly in cases seen in the adult and pediatric emergency rooms at University of Maryland Hospital.

The MPIC wishes to thank community pharmacists for their involvement in our Poison Prevention programs. We have in the past, distributed poison prevention materials at no cost, or for a small donation, to community pharmacies. Should pharmacists wish to obtain additional materials for distribution they are advised to call 528-7604. We strongly recommend that all parents with children under 5 years of age keep a bottle of syrup of ipecac in their home. We hope that all pharmacies will keep syrup of ipecac in stock to be sold in emergencies and to be recommended to parents of young children to be kept in their home as a precaution.

Should you be involved with an ingestion, the MPIC is available 24 hours per day to help you. Call (301) 528-7701 from metropolitan Baltimore or 1-800-492-2414 toll free from other parts of Maryland.

Letter to the Editor

Dear Sir:

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(301) 327-2020

Sincerely,
David Boehlke
Director of Marketing
Neighborhood Housing
Services

calendar

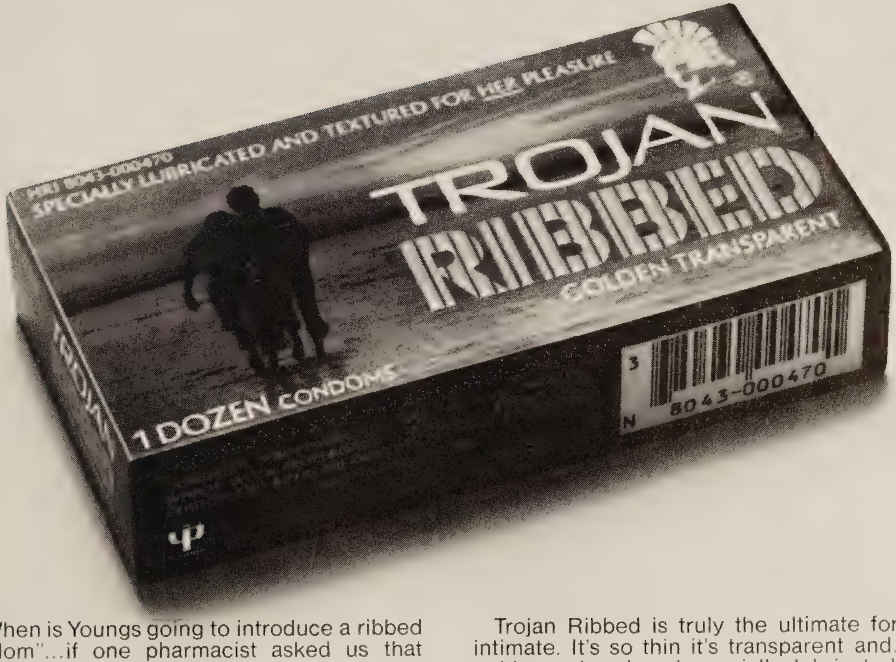
October 2-6 — NARD Convention at Washington, D.C.

October 10-18 — MPhA Trip to Rome. Plan NOW!!

October 27 (Thursday) — MPhA Fall Regional and House of Delegates Meeting.

November 19 (Thursday) — MPhA Simon Solomon Pharmacy Economics Seminar

The best is always worth waiting for...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THE
MARYLAND
PHARMACIST
Official Journal of
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Association
JULY 1977
VOL 53
NO 7

David A. Banta
MPhA New Executive Director

An Introduction

Proceedings of the MPhA 95th Annual Convention

Fall Regional and House of Delegates Meeting
Thursday, October 27, 1977

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
TELEPHONE 301/727-0746

JULY 1977 VOL. 53 NO. 7

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dications: Acute, recurrent or chronic urinary tract infec-
ns (primarily pyelonephritis, pyelitis and cystitis) due to
sceptible organisms (usually *E. coli, Klebsiella-Aerobacter,*
aphylococcus, *Proteus mirabilis* and, less frequently,
oteus vulgaris), in the absence of obstructive uropathy or
reign bodies. Note: Carefully coordinate *in vitro* sul-
namide sensitivity tests with bacteriologic and clinical
sponse; add aminobenzoic acid to follow-up culture
edia. The increasing frequency of resistant organisms
nits the usefulness of antibacterials including sul-
namides, especially in chronic or recurrent urinary tract
fections. Measure sulfonamide blood levels as variations
ay occur; 20 mg/100 ml should be maximum total level.
ontraindications: Sulfonamide hypersensitivity; preg-
ancy at term and during nursing period; infants less than
vo months of age.
Varnings: Safety during pregnancy has not been estab-
shed. Sulfonamides should not be used for group A
eta-hemolytic streptococcal infections and will not eradi-
ate or prevent sequelae (rheumatic fever, glomerulone-
hritis) of such infections. Deaths from hypersensitivity reac-
ions, agranulocytosis, aplastic anemia and other blood
yscrasias have been reported and early clinical signs
sore throat, fever, pallor, purpura or jaundice) may indi-
ate serious blood disorders. Frequent CBC and urinalysis
vith microscopic examination are recommended during
ulfonamide therapy. Insufficient data on children under
ix with chronic renal disease.
Precautions: Use cautiously in patients with impaired renal
r hepatic function, severe allergy, bronchial asthma; in glu-
ose-6-phosphate dehydrogenase-deficient individuals in
vhom dose-related hemolysis may occur. Maintain ade-
quate fluid intake to prevent crystalluria and stone formation.
Adverse Reactions: *Blood dyscrasias* (agranulocytosis,
aplastic anemia, thrombocytopenia, leukopenia, hemolytic
anemia, purpura, hypoprothrombinemia and methemo-
globinemia); *allergic reactions* (erythema multiforme, skin
eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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An Introduction

David A. Banta

MPhA New Executive Director

David A. Banta, the new Executive Director of the Maryland Pharmaceutical Association was appointed at the Association's 95th Annual Convention in Ocean City, Maryland. Dave comes to Maryland after nearly four years of experience as Assistant Executive Director of the Indiana Pharmaceutical Association where he had broad responsibilities for membership services and benefits as well as Association administration.

Dave received his B.A. degree in journalism from Ohio State University in 1969. After a tour of duty as an Army Officer with a Hawk Missile Battalion for two years, he continued his studies at Ball State University where he received his Masters degree in journalism and public relations.

Prior to working with the Indiana Association, Dave had been employed as News Director for radio station WBST-FM in Muncie, Indiana and as Veteran's representative with the Indiana Employment Security Division.

In the Indiana Association, Dave was primarily responsible for publication of the Association's newsletters and the monthly journal, *The Indiana Pharmacist*. Dave was also a registered lobbyist for the I.Ph.A. and while working with Dave Clark, the I.Ph.A.'s Executive Director, represented Pharmacy interests in the Indiana General Assembly.

Dave gained experience in Association management, convention planning, C.E. program implementation, membership promotion, Association photography, Committee staff liaison, as well as all phases of public relations planning for pharmacy.

While in Indiana, Dave authored slide presentation narratives on the topics of *Membership Promotion, Drug Product Selection* and *Association Government Relations*. In addition, he developed the art-work for these presentations and produced the photography.

In addition to the speeches he has presented to state and local association meetings, Dave has addressed the National Council of State Pharmaceutical Association Executives on the subject of State Pharmaceutical Association Public Relations. Dave has authored a number of articles for the Association's journal and has one script copyrighted.

Dave is a member of the Indiana Business Communicators, the Indianapolis Press Club, the Hoosier Chapter of the Public Relations Society of America and the Indiana Society of Association Executives. He has served on the Professional Education Committee of the American Cancer Society, Indiana Affiliate, and the Indiana Immunization Action Month Committee.

Dave has represented the Indiana Association in the Indiana Coalition of Retail Associations and the Consortium of Health Care Provider Associations.

David Banta (right), MPhA's new Executive Director, is greeted by Milton Friedman (left).

Courtesy of Paramount Photo Service

Dave most recently attended the week-long Institute for Organizational Management sponsored by the United States Chamber of Commerce at Notre Dame University. The Institute is specifically designed for Association Executives and assists them in dealing with the highly specialized field of Association management.

Dave is married to the former Jan Livensparger, who was born in Baltimore. They have two sons — Scott, aged four, and Matthew, age two.

Dave is looking forward to meeting the Association members personally, and will attend as many local association meetings as scheduling will allow.

calendar

August 11 (Thursday) — TAMPA Crab Feast — Libertini's — $10.50 — Tickets available from major wholesalers

September 8 (Thursday) — Maryland Society Hospital Pharmacists Meeting — Johns Hopkins Hospital

September 11 (Sunday) — MPhA Dinner Theatre. Colony 7 Motor Inn. "Man of LaMancha."

September 20 (Tuesday) — Alumni Association Meeting.

September 27 (Tuesday) — BMPA Meeting — Pharmacy Law revision.

September 29 (Thursday) — State-MPhA Seminar on Laws and Inspections — Sacred Heart Hospital — Cumberland.

October 2-6 — NARD Convention, Washington, D.C.

October 10-18 — MPhA Trip to Rome — Limited Seats — Reservation deadline approaching.

October 27 (Thursday) — MPhA Fall Regional — House of Delegates Meeting.

November 19 (Tuesday) — MPhA Simon Solomon Pharmacy Economics Seminar.

Proceedings of the 95th Annual Meeting Maryland Pharmaceutical Association Carousel Hotel, Ocean City, Maryland June 19-22, 1977

The 95th Annual Convention of the Maryland Pharmaceutical Association began with a welcome cocktail party and presidential reception for Melvin N. Rubin at 9:30 p.m., Sunday, June 19th. An ice show was the featured entertainment attraction.

The opening General Session was called to order Monday, June 20 at 9:10 a.m. by President Melvin N. Rubin. Convention Chairman Ronald Lubman brought greetings and made a number of announcements. The President then called on the representatives of various affiliated and recognized organizations in attendance as follows:

Anne Arundel Pharmaceutical Association: Vincent Regimenti,
Allegany-Garrett County Pharmaceutical Association: Ernest Gregg, Jr.,
Prince Georges-Montgomery County Pharmaceutical Association: Leonard DeMino,
Upper Bay Pharmaceutical Association: Charles Bernard,
Eastern Shore Pharmaceutical Society: Vincent Gattone,
SAPhA: Russell LeSage,
Maryland Society of Hospital Pharmacists: Thomas Patrick,
School of Pharmacy: Donald O. Fedder,
Metropolitan Guild of Pharmacists: Frederick S. Firnbacher.

President Rubin then stated that as his annual report had been published in THE MARYLAND PHARMACIST April issue, he would not expand any further at the time. He then called upon Henry G. Seidman, Chairman of the Board of Trustees, who presented the following report:

"The Board of Trustees of the Maryland Pharmaceutical Association has acquitted itself well in the discharge of its responsibilities during the past year.

"It is to be commended for its determination to act on changes that have become necessary in the direction of the administrative office. Additional changes in whatever ways are still deemed advisable and essential will demand continued understanding and support of the Board. The membership, too, must do its part by participating in committee assignments and by supporting all association activities in the year ahead.

"I have no intention of reviewing the activities of the association for the past year in this report. This will be done in some detail by the committee chairmen whose reports will be submitted to you, and to a broader extent by the president in his message to you this morning.

"I do, however, wish to express my appreciation to the members of the Board of Trustees who gave of their time and of themselves to attend regular Board meetings each month, and special meetings as provided for in our Constitution and By-Laws. Since the strength of any organization is in unified action and thought when it faces any problem, I hope that our board is ready to demonstrate its ability to lead in the best interest of the Association and of pharmacy.

"I have had the distinct pleasure and rare privilege to preside over the Board meetings during the past year, and I am grateful to all of you for having made that circumstance possible. I ask the Board to continue its diligent tasks and to assist and advise its new chairman. He, too, is thinking foremost of MPhA and pharmacy.

"I would like to return to the board should that opportunity present itself; I believe that here is where the action really is.

"Thank you."

Treasurer Anthony Padussis was then called upon to present the Treasurer's Report covering the Association's fund balances, income, and disbursements for calendar year 1976. There was discussion regarding the scholarship fund. The report was accepted. The audited report is on file at the Association office.

Executive Director Nathan I. Gruz then presented his report:

"Mr. President, fellow members of the Maryland Pharmaceutical Association, honored guests and friends. This is my 16th Annual Report as Executive Director. The past year has been one of great ferment for the Association — a period calling for great inner strength and patience on my part. I hope I have succeeded.

"Pharmacy, nationally as well as in Maryland, has arrived at a stage that now requires more than ever acknowledgement of certain realities. Community pharmacy is moving ever more rapidly into a situation where institutional pharmacy, governmental pharmacy and giant corporate pharmacy is affecting opportunities for individual entrepreneurships. New ownership opportunities exist now and will exist, but only with more careful selection of sites, more astute management, more resourceful cooperative arrangements and more effective professional services to patrons or *patients*. EDP computers must become an integral part of all pharmacy practice. In relation to population, there will be fewer pharmacies — more people per pharmacy.

"Pharmacy is belatedly returning to a single professional degree, which must and will be the Doctor of Pharmacy degree. Specific credential programs will be developed for clinical pharmacists, nuclear pharmacists and so forth.

"Pharmacists will have to become more realistic in regard to what kind of organizations they want to represent them. In order to compete in the same league of big business, big labor, big institutions and big government, there will have to be what has been recognized for a long time — a unified organizational force for pharmacy practitioners on the national level. At the state level, hospital pharmacists and community pharmacists — both chain and independent — will have to support a unified state organization. For the smaller states, such as Maryland, there is no alternative. There just are not enough independent owners anymore to carry the major load financially. If salaried pharmacists cannot recognize the professional and economic stake they have, then everyone in pharmacy will go down the same drain together. If pharmacists have not arrived at the point where they see that without representation before government and before the legislature they will be completely powerless, then they will deserve the laws and regulations they will have to live with. Every other group is in Washington and Annapolis with representatives and lobbyists. All this takes manpower and money. Few pharmacists can give the time. They must have organizations adequately staffed to work and fight — night and day — 12 months a year.

"As for myself, I don't know what our future will bring. But I hope and plan to continue working for better health care for everyone — through pharmacy and through every means possible.

"I am grateful for the many wonderful people who have voiced their appreciation of my efforts for the Association and for pharmacy over the years. I will always continue to contribute in any way in which I am capable. I look at the positive side and thank you for all the rewards of working and fighting for good causes."

Following Mr. Gruz's presentation, Charles E. Spigelmire moved that a unanimous vote of appreciation be given to Mr. Gruz for his many years of devoted service to the Association. The motion was passed by acclamation.

Report of Maryland Board of Pharmacy

In the absence of Robert E. Snyder, Secretary of the Maryland Board of Pharmacy, Bernard Lachman, a Commissioner of the Board, was called upon. Mr. Lachman stated that no written report was available as called for by Section 258 of Article 43 of the Annotated Code of Maryland to be presented to the Governor and to the Maryland Pharmaceutical Association. Mr. Snyder had stated that because of lack of funding and staff, he was unable to prepare a report. Mr. Lachman presented a brief historical review of the operations and functions of the State Board of Pharmacy and Division of Drug Control. He described the current situation which has prevented the Board from effectively carrying out all of its functions as the State is not providing all of the funds which the Board is collecting in fees and licenses. He announced that the Environmental Health Administration had agreed to abandon the point system in rating inspections of pharmacies and that regulations would be promulgated to permit prescription refills to be recorded on patient profiles as well as on the back of prescription orders.

During the Board of Pharmacy Report and the discussion, Mr. Rubin turned the Chair over to Vice President Stanley Yaffe for an interval.

In the absence of Dean Kinnard, Donald Fedder was called upon to comment on activities of the School of Pharmacy. He stated that task forces at the school are looking at the curriculum and other recommendations in the Mills Commission Report. The class of 1980 will have 92 students, 50% of which are women. Funds for new building were approved and construction should begin by early next year. In connection with the issue of a single or dual degree for pharmacy graduates, there is a division of opinion at this time in the School of Pharmacy as well as throughout academia.

HOUSE OF DELEGATES

At 10:30 a.m. the Chair was turned over to Victor H. Morgenroth, Jr., Speaker, to convene the House of Delegates. The Speaker called for a brief recess and the session reconvened at 10:45 a.m. The Speaker designated Past President Earl Kerpelman as Parliamentarian. Mr. Morgenroth then spoke of the problems in pharmacy during the past thirty (30) years, quoting from THE MARYLAND PHARMACIST of 1948 and pointing out that many of the problems were still with us. The Speaker then asked for Committee Reports.

Finance Committee — Stanley Yaffe, Chairman

The Finance Committee met and projected a budget of $76,750.00 for 1977. It was based on increasing sustaining member contributions, more advertisements in a Convention issue of the Journal and support from allied groups. However, the results have not been up to expectations. Steps have been taken to curtail costs and expenditures as much as possible.

Income and expenditures are now under more frequent review. My recommendation is for the Board of Trustees to urgently look into sources of additional income and to curtail all possible expenses.

In discussing the report, Mr. Yaffe recommended consideration be given to an increase in dues and further work to increase membership. A priority for the coming Association year will be the examination of finances. The report was accepted.

Public Relations Committee — Charles E. Spigelmire, Chairman

Mr. President, Distinguished Guests, Members of the Maryland Pharmaceutical Association.

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During the past year, your committee has tried continuously, and vigorously to emphasize the importance of the community pharmacist to the public. We have worked on the theory that if you repeat a statement often enough, long enough, and loud enough, the majority of the people will listen to it.

We realized full well there have been tremendous inroads made in our profession and patronage during the past years, without stern retaliatory publicity measures being taken. It must be remembered that we felt the best results could be obtained for the community pharmacist by trying to fight this competition by publicity emanating from both local and state levels.

At the local and state levels your committee felt it could control efficiently any type of publicity action we decided to take. Your committee realized that the methods of important publicity for the community pharmacist were limited, but the sources of available publicity for the Association were radio, television, newspapers, and magazines.

Knowing full well that the great audio and visual audiences of today were primarily interested in radio and television we decided to explore these fields of publicity and entertainment in an effort to have our publicity emanate from these media.

Every Sunday morning during the past year, you received a continuous flow of favorable publicity over radio station WCAO. These radio programs were informative, helpful, and most enlightening concerning the numerous and confusing problems facing pharmacy practice today. Each broadcast tried to answer some of the important and difficult questions which have confronted our profession during the past year. We felt this time was used most judiciously when it helped you preserve the most priceless asset you have and that is a satisfied patron.

In a program defending prescription costs we tried to make your patrons realize the pharmacist's contribution to the medicine that they all too often take for granted. The dispensing pharmcist's own years spent in college, his knowledge of the chemistry, biology and the physics of medicinal substances, his mature judgement in matters of an extremely confidential nature between the physician and the pharmacist: these factors, too, are built into the cost of that medicine.

We felt the community pharmacist must, as the "front-line" of the entire profession, get these facts across, at the prescription counter or at his civic organization or in his community groups. He must do this for the future of his colleagues, he must do this for his own future security.

When he sees the better part of a five dollar bill go for a prescription, the patron should know the bargain he's getting in health. If he understands what's in the pill he swallows, I assure you, you'll have a friend for yourself and for all of pharmacy.

In a program designed to emphasize the true profession of pharmacy and to strengthen professional thinking

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PROMPT DELIVERY
ASTRO CO-OP CIRCULAR PROMOTION
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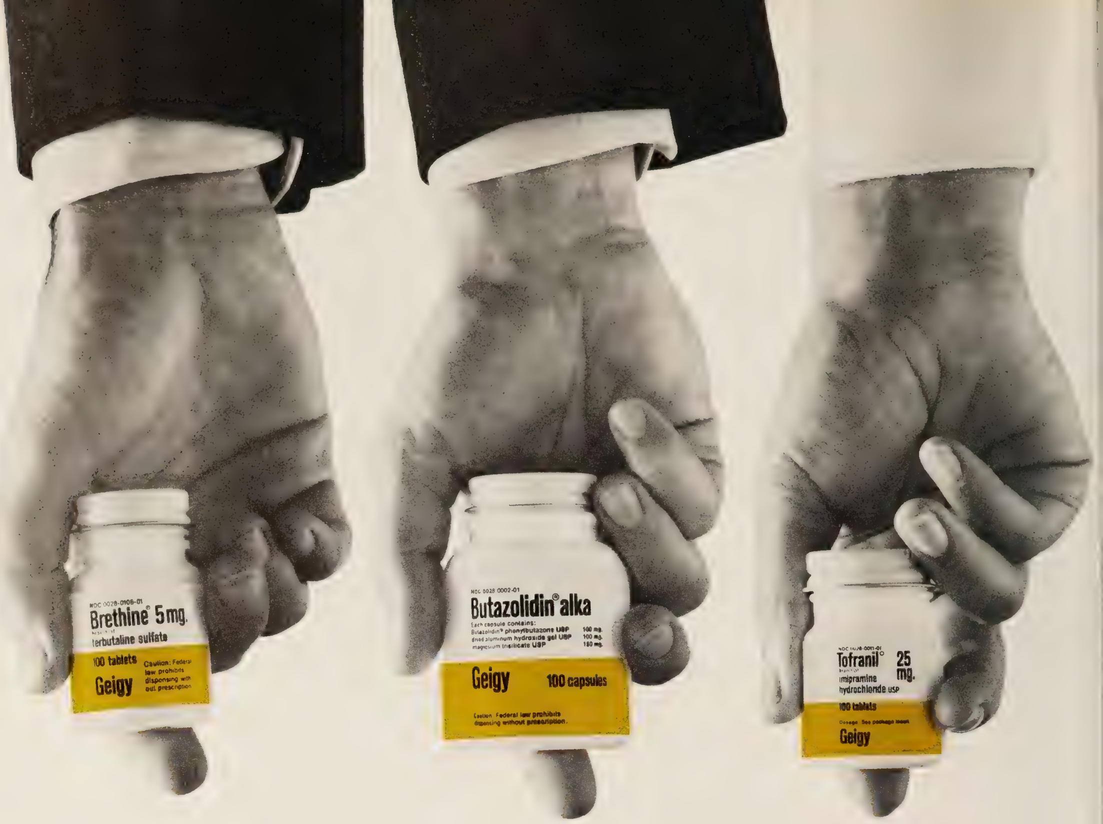

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Dispense with insurance.

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This agreement by **Geigy** Pharmaceuticals to indemnify and hold harmless, as set forth above, is expressly conditioned upon the pharmacist, or his employer, immediately notifying the Company of any claim, demand, or the service of any complaint. This

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This agreement is not applicable if **Geigy** Pharmaceuticals determines that there is evidence of any improper or negligent statement or act, or omission to act, by the pharmacist, or his employer, or if **Geigy** Pharmaceuticals determines that there is evidence that the product has not been properly stored or properly dispensed.

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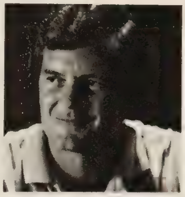
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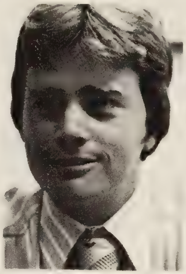
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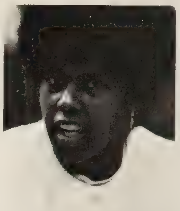
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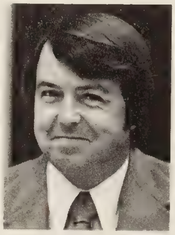
TIM BRODERICK

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we stated that only through good inter-professional relationship between the two professions and through mutual respect and confidence can the two professions best service society and medicine. At the present time, it is the work of every pharmacist on the local level to convince physicians, either individually or as members of local and state medical societies, that the dispensing of drugs and clinic pharmacy ownership are bad not only for the patient, but for the physician himself, and the medical profession as a whole.

Pharmacy's position on the health team will not be endangered if diplomacy and statesmanship are used by pharmacists; in fact, pharmacy can rise to great heights if pharmacists will take time to cope with the situation and make adjustments as time goes on. The future of pharmacy is in your hands; guide it carefully.

Another program gave our listeners a very enlightening and comprehensive store of the many laws and regulations governing the practice of pharmacy and how they helped to protect you and the public, but I must say that too often, the pharmacist believes that through legislation he can restrict the sale of drug products to the drug store, and with this idea, he sits back and basks in the sunshine of yesterday's volume feeling that when things become rough, all he has to do is to go to the legislature and pass another law. In the meantime, mail order houses, door to door salesmen and non-drug retailers are taking away his vitamin business. Pharmaceutical manufacturers and wholesalers are ready and willing to help the pharmacist gain the volume lost. The stimulus for increasing sales must come from the pharmacist himself and this stimulus must be extended to all personnel in the pharmacy.

One of our most interesting programs was one on which we asked the question "Why do you patronize your favorite pharmacy?" Everyone answering received by return mail a vitamin chart describing the functions and uses of the various vitamins. From the answers we found most people patronize their pharmacy because of confidence in the pharmacist, not because of bargain prices. The integrity of the individual pharmacist is unquestioned. If the price alone were the factor, the customer would be attracted to the store front with the most flamboyant signs; professionally, this is not the case.

Your committee felt it had an excellent opportunity to tell the public how vitally important the community pharmacist was to its health and welfare, because his service to them was not of one week's duration, but rather a year round dedication. The many and varied services of the community pharmacist were explained to the public time and again through the media of newspapers, radio and television.

Statistics prove there are still many small children under five years of age dying because of accidental poisoning — poisonings that were caused by the negligence and carelessness of adults. During Poison Prevention Week we worked hard and diligently to tell the public that the surest way to eliminate these horrible occurrences, was to keep all medicines out of reach of small children. Through radio, television and newspapers the community pharmacist told the public that some of the surest ways to eliminate poisoning in the home were always to read the label, never take medicine in the dark, and never give another person your medicine or prescription. During Poison Prevention Week, you the community pharmacist distributed thousands of descriptive flyers to your customers which told that aspirin was the greatest killer of all and that it is the only drug, when taken in lethal doses, for which there is no antidote.

During Foot Health Week, your committee presented a very fine program on foot health. This program not only told our audience the many problems involved when the feet did not receive proper care, but it also explained the many, many ways in which the community pharmacist cooperated with the podiatrist to develop and maintain excellent foot health.

Cancer, they say, attacks us like a thief in the night, yet many people suffer and die from this disease because they will not seek treatment or advice soon enough, despite its warning signals. We pointed out the warning signals of cancer. We explained the procedure to follow at the first sign of any cancer symptoms. We told of the sophisticated treatment and research being done by the Cancer Society to eliminate this scourge of mankind. In all of these broadcasts we always let the public know that any and all of the remedies and medications used in the treatment of cancer were available at their community pharmacy.

Cardiac disease is as old as mankind itself. During Heart Month your committee was most cooperative with the Heart Association telling the public how important proper medication and care were for the victim of any type of cardiac ailment. In view of the fact that most cardiac sufferers need perpetual therapy and long-term medication, we pointed out that the person who had a sincere interest in their physical and financial welfare, was you, their best neighbor.

Have you met someone today who thinks "Baltimore is Best"? Most of our pharmacists have, because in a cooperative effort with Mayor Donald Schaefer's "Baltimore's Best" campaign, our pharmacies are distributing "Baltimore's Best" cards in their stores to support this activity.

Time and space do not permit me to describe each and every radio program presented on station WCAO during the past year because there were 52 of them. I can tell all of you this, that as long as I am your chairman, these programs will always say that the pharmacist *is, has been, and always will be the public's "Best Neighbor"*.

At radio station WCAO in Baltimore our appreciation goes to Mr. Joseph Cahill, station manager, Mr. Ron Riley, director of public service, and Mr. Ernest Boston, program director. Another motivating force in our success during the past year was the advice and cooperation of our Executive Director, Nathan I. Gruz.

My sincere thanks for the helping hands of all the office staff.

Just keep on trying and the chances are that you will stumble on something, perhaps when you least expect it.

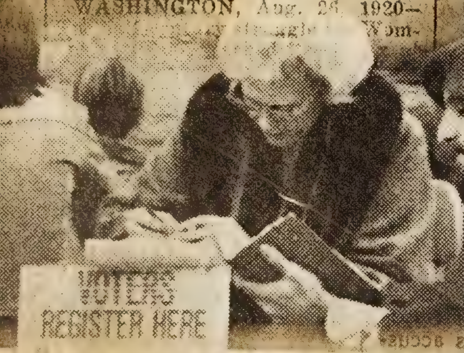
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jo

Roosevelt Approves Message Intended to Benefit 30,
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug.
The Social Security Bill,
a broad program of unem
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those chiefly responsible
ting it through Congress.

Mr. Roosevelt cal [illegible]
"the cornerstone [illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES NITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGN

the Dra
Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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* Data on file, Lederle Laboratories

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063-7

I have never heard of anyone stumbling on something sitting down.

A proposal for a resolution thanking radio station WCAO AM and FM for its outstanding cooperation in furnishing program time was referred to the Resolution Committee. The report was accepted.

Legislative Committee — Richard D. Parker, Chairman

Complete reports were presented at the Fall and Spring Regional House of Delegates meetings. In order to avoid repetition, this report will therefore only be to bring the year up to date.

The most important action was the choice by the Governor of House Bill 667 (as amended) as the Drug Product Selection bill signed into law. Senate Bill 418, which started out as a companion measure, but ended up as a bill amended at variance from H.B. 667, was vetoed.

We have worked hard over the years to get laws that are fair to all parties concerned, the public as well as pharmacy and the pharmaceutical industry. H.B. 667 is a good compromise bill. It is permissive, not mandatory, for both physicians and pharmacists. The public will benefit from quality drugs at lower, reasonable costs for many products.

We did lose the continuing education bill, but we will again try to come up with a bill acceptable to all.

Chairman Parker added that a proposed comprehensive revision of the Maryland Pharmacy Practice Act developed under the auspices of the Tripartite Committee must be thoroughly studied by the Association and all those affected by the Act. The report was accepted.

Membership Committee — Elwyn Alpern, Chairman

The Membership Committee of the Maryland Pharmaceutical Association has conducted two major projects during the past year to increase the membership of the Association. Since January, the committee has cited the benefits of membership to several affiliated associations, either in conjunction with the joint MPhA-School of Pharmacy Continuing Education Program on auxiliary labeling or through MPhA sponsored events.

The committee also conducted a general mailing to non-member pharmacists registered in Maryland. Since that mailing, the Association has received dues from twenty new member pharmacists. This brings our membership total as of June 2nd to 858 members compared to 785 the same time last year. The largest increase was in the student chapter (SAPhA) of the Association. Last year's total of 77 SAPhA members was more than doubled by the count of 177 registered this year.

As Chairman, I would like to thank Philip Cogan, Edward Nussbaum and Melvin Rubin, as well as the Executive Director, Nathan Gruz and his Assistant, Richard Schulz, who assisted me this year in trying to increase the membership of our Association.

The report was accepted. A motion duly made and seconded was passed to commend the Membership Committee for its dedicated efforts during the past year.

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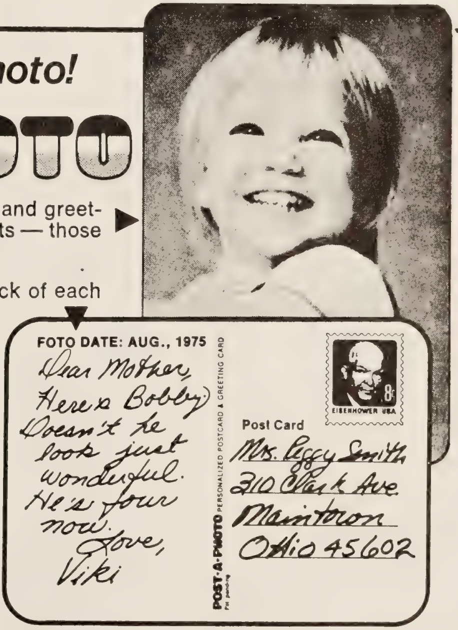

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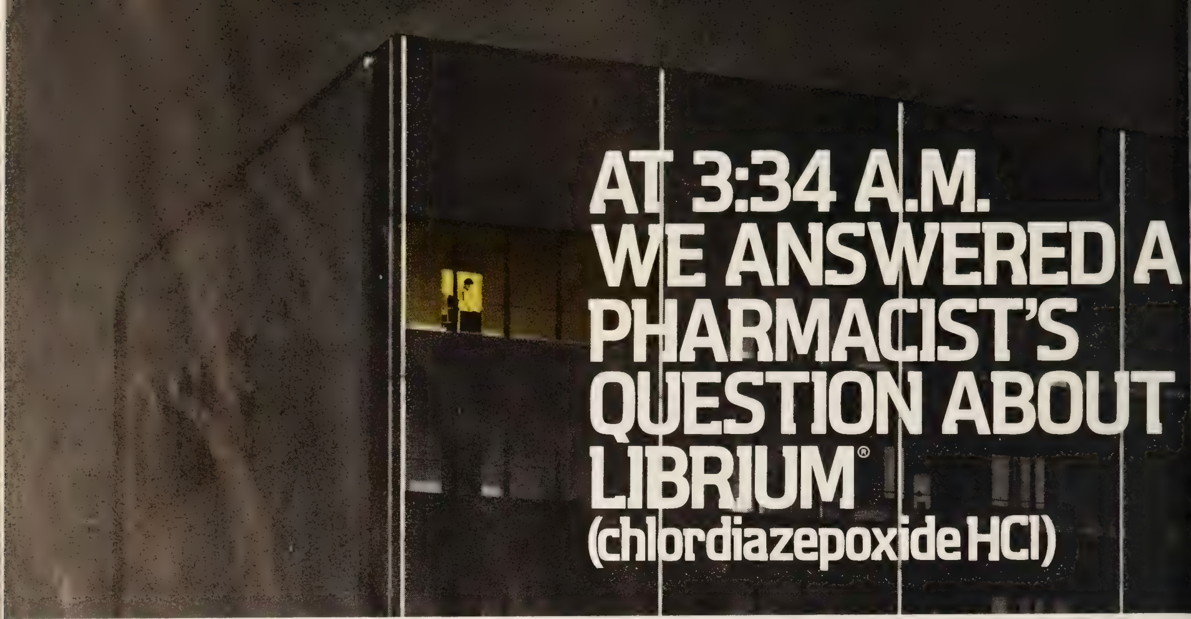

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indi-

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cated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Prescription Insurance (third party) Committee —
Marvin Friedman, Chairman

Mr. Friedman stated that the State Department of Health and Mental Hygiene had recommended a 25¢ increase in the prescription fee for Medicaid effective July 1, in spite of the Lasser Report. Second, the implementation of the first MAC was scheduled for June 27th on the HEW guidelines for Ampicillin capsules. Third, the Medicaid Liaison Committee has met under Chairman Donald Schumer. He acknowledged that there have been improvements in the administration and processing of duplicate bills, but that the problem of reimbursement for HMO prescriptions is not completely resolved, and that certainly the problem of an equitable fee has not been resolved. He felt there were inequities in the payment of nursing homes compared to community providers. He recommended that the resolution at the Spring Regional Meeting regarding possible legal action should be considered and voted on at this Convention.

Mr. Schumer then reported on work on unpaid bills and discussions on submission of bills for EDP processing for community pharmacies through such means as tape to tape. An additional administrative fee would have to be paid to community pharmacies for this service, but the State would still be saving money.

Mr. Morgenroth announced a conference, sponsored by the American College of Apothecaries, will be held July 21-22 on third party matters in Memphis. It was suggested that the Prescription Insurance Committee Chairman be sent to this meeting.

Peer Review Committee — Irvin Kamenetz, Chairman

The chief function of the Committee over the past year has been to answer complaints concerning pharmacists and pharmacies. We have followed the procedure using the system previously established. Each complaint was fully investigated; the persons involved were contacted; and in each case the matter was satisfactorily resolved. A few recurring complaints indicate the public appears to be confused regarding the services that a pharmacy renders. Some of the people have apparently assumed that all pharmacies are required to give the information which only patient profile records could make available.

For next year we recommend that the role of the Peer Review Committee might be clarified in relationship to Third Party providers. Another suggestion is that pertinent publicity be provided so the general public will be more fully apprised that a "complaint department" exists and is available at all times.

The Chairman also recommended that further guidelines for the Committee should be developed. The report was accepted.

Tripartite Sub-Committee on Pharmacy Practice Act Revision — Paul Cuzmanes, Coordinator

Mr. Cuzmanes reviewed the proposed comprehensive revision of the Maryland Pharmacy Act pointing out the most significant changes and recommended MPhA input. There was discussion of the need for MPhA to publicize the proposals and for the Association to call such meetings as would be indicated to explain the proposed provision.

Tripartite Committee — Donald O. Fedder, Coordinator

The auxiliary labeling guide and the proposed Pharmacy Act were reported on.

Industrial Relations Committee — George Stevenson, Chairman

MEETINGS: have been held on August 17, September 28, December 7, 1976,
February 15, March 29, and May 10, 1977.

ACTIVITIES:

A *Increasing of membership of pharmaceutical sales representatives.* May, 1977 shows 18 members in this area — 16 companies (two companies have two members each). This 18 added to 9 wholesaler representatives and four other distributor members, gives a total of 31 members in the sales area.

B *Contacts with Pharmaceutical Manufacturers Association and National Pharmaceutical Council* explaining our purpose and activities, asking for their help.

C *Invitational letter* sent to industry personnel to attend our 1976 Fall Regional Meeting — response was excellent — 37 letters sent; 18 attendees from 17 companies.

D *Invitational letter* sent to industry personnel to attend this Convention — 38 letters sent — a good response is anticipated.

E *Standardized labelling format for prescription drugs* – committee recommendations sent to FDA. Committee is arranging for key MPhA personnel to meet with PMA representatives to discuss this area in September 1977.

F *Community Pharmacy Training Program for new sales representatives* – Jerry Block is chairing a subcommittee for the development of a "Day in the Pharmacy" Training Program. One Burroughs Wellcome representative has been through this program (currently one day) at Jerry's Pharmacy and commented, "I would encourage all new representatives to participate in such a program. It would help the representative in understanding the pharmacist's point of view and vice versa."

The committee has also discussed many other areas, including: problem of outdated products and their possible pick-up by manufacturers for exchange or credit — the making of package inserts more accessible — the possibility of manufacturers providing PDRs to the pharmacist — the problem of obtaining bio-availability information from some manufacturers — the providing of manufacturers returned goods policies to MPhA members.

Please remember, this committee is also your liaison with pharmaceutical manufacturers and is anxious to help you and industry solve any misunderstandings or differences. In this area, the committee should be con-

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```
TAME CR RIN   8 OZ.
 #5681        QTY 2
334            1.25
          7312-1359
```

```
YOUR NAME
     $1.25
       4MP
2 032
7312-1359
```

RX MERCHANDISE

```
BENTYL       TAB 20MG
100          QTY 1
NDC 68-0123-61
            2437-1576
```

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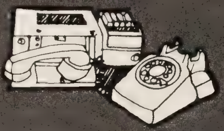
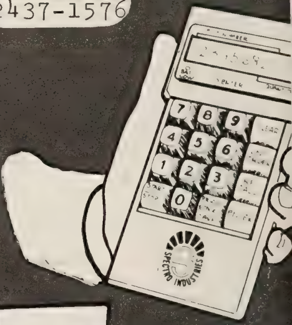
NDC    68
0123-61
   5D70
  1 032
2437-1576
```

Electronic Order Entry System

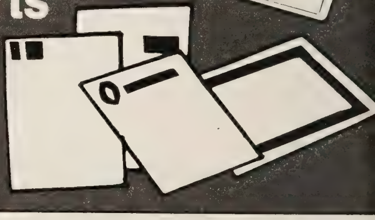
Electronic order entry Terminal for in-store use. It's lightweight, portable and enables you to order 200 line items in less than one minute. Transmits over telephone. Operational 24 hours a day . . . call at your convenience.





Turnover and Profitability Reports

Customized series of ongoing Turnover and Profitability Reports for Your Store. Helpful information compiled from product movement of items in your store.



CHECK THE *BIG PLUS FEATURES:*

- Store Identification Labels.
- Complete Product Information.
- Complete OTC and RX Pricing Stickers.
- Quarterly Label Color Change.
- Tamper-proof (non-transfer) security.
- Ink Screening of Coded Information.
- Deal Contents Have Price Stickers.
- Price Stickers for Selected Full Cases.
- NDC Numbers on All RX Products.
- Customized Pricing.
- Two Price System.

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CITY ______ STATE ______ ZIP ______

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Dioctyl Sodium Sulfosuccinate Capsules USP
100 mg
Ferrous Gluconate Iron Supplement
300 mg
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500 mg
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Ferrous

We have over 600 representatives trained to sell pharmaceutical products.

If you don't want to deal with mail-order generic companies, or sales reps whose only service is filling orders, try Lederle.

We'll give you personal service—with people who can understand your problems and will try to help you solve them.

We can increase your purchasing power. A.I.M. is the way, the Lederle Automated Inventory Maintenance plan that lets you order your annual requirements with volume discounts, and pay only as merchandise is received per your shipment specifications.

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Brand-tested generics. Duplicate batch assay testing which meets Lederle branded product standards. All products are dated.

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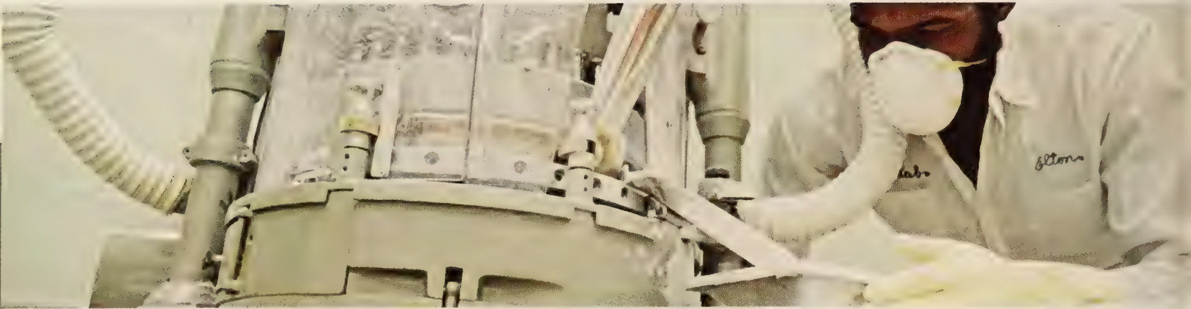


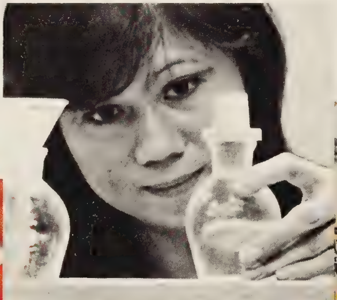
If a Standard Product isn't good enough to carry the Lederle name, we won't sell it.

That's why we make every one of our over 70 Standard Products pass the same quality control testing procedures that all Lederle products must pass.

Those products, made to our specifications by outside contractors, are actually tested twice.

First, by the producer and then by Lederle in our own quality control laboratories.

If you want quality assured by dual batch assay testing and the added protection of an expiration date on every package, as well as personal service from one of over 600 sales representatives, buy Lederle Standard Products.



With our 70-year reputation for quality and service, we can't afford to let anyone take a short cut.

Ferrous Sulfate
Dioctyl Sodium Sulfosuccinate Capsules USP 100 mg
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For complete details, call your Lederle Sales Representative

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tacted in writing, giving all details of the specific problem.

Mr. Stevenson invited all in attendance to a dutch treat breakfast meeting on Wednesday morning. The report was accepted.

Swain Pharmacy Seminar — Philip Cogan, Chairman

The 1977 Robert L. Swain Pharmacy Seminar was held on March 17, 1977 at the Towson Quality Inn. Approximately 60 individuals attended and a small profit was realized. This was very reassuring because it again demonstrated that continuing education programs can be self-sufficient.

The morning session opened at 9:00 a.m. and was devoted to the pharmacist's role with relationship to regulatory agencies. Mr. Melvin Rubin presided and handed the meeting over to seminar chairman, Philip H. Cogan.

The first item on the agenda was a panel consisting of:

Mr. Ronald W. Buzzeo, Drug Enforcement Administration
Mr. Charles H. Tregoe, Maryland State Division of Drug Control
Mr. I. Earl Kerpelman, Maryland Board of Pharmacy

The discussion centered around what was expected of pharmacists in dealing with Dangerous Controlled Substances.

The second item on the morning agenda was a discussion of safety closures and new container requirements. This was presented by Mr. George Maisel of the U.S. Consumer Product Safety Commission.

The luncheon speaker was Robert C. Pinco, former Director of the U.S. Food and Drug Administration Over-The-Counter Drug Evaluation Division. He spoke on the implications for the pharmacists in the future with respect to over-the-counter drugs.

The afternoon sesssion was divided into two portions: the first, "The Pharmacist's Role in Supplying OTC Drugs," was moderated by Dr. Ralph Shangraw and included a talk on "Providing Information to the Public — Legal Aspects" by MPhA Legal Counsel Joseph S. Kaufman. This included ramifications of permitting clerks to give medication information. The second portion was a panel discussion on "Non-Prescription Drugs — A Case Study, Laxatives and Anti-Diarrheals". This was also moderated by Dr. Ralph E. Shangraw. Dr. J. Edward Moreton, of the University of Maryland, discussed the "Anatomy and Physiology of the Gastro-Intestinal Tract"; Mr. Robert C. Pinco discussed "Drug Products and the OTC Review"; and Dr. John M. Hoopes, of the University of Maryland, discussed "Patient Assessment and Management". The seminar closed at approximately 4:45 p.m. after brief questions and answers on the afternoon session. Six hours of continuing education credit were given.

The report was accepted.

Executive Director Search Committee — Donald O. Fedder, Chairman

Early in the fall of 1976, President Rubin with the approval of the Board of Trustees (BOT) appointed a Search Committee to locate a suitable candidate for the position of Executive Director of the Maryland Pharmaceutical Association. The committee met, elected its own chairman, and proceeded to define the task and to write the job description (J.D.) for the executive director. Upon approval of the J.D. and the budget by the BOT, the committee advertised and contacted interested persons in order to develop a list of prospective candidates for consideration.

The first effort produced 27 candidates and a recommendation to hire one of these. After a thorough investigation by the BOT, the candidate was offered the position, subject to the acceptance by the House of Delegates. Just prior to the spring meeting of the House, the candidate removed his name from consideration. The House then voted to continue the search and the committee returned to its task with renewed vigor.

This second effort produced approximately 100 applicants and resulted in a recommendation of a candidate to the BOT which has been made and accepted at this meeting.

The committee conducted 12 interview sessions, as well as numerous applicant-reviews. The total cost of the search was $712., $288. under budget.

I should like to thank the applicants, the members of the committee and the staff, both in the Association office and the School of Pharmacy who cooperated so beautifully.

Convention Committee — Ronald Lubman, Chairman

Mr. Lubman recommended the Carousel to the Board of Trustees as the Convention site for 1978. He urged attendance for the MPhA trip to Italy, October 10-18 and announced a possible trip to the Caribbean in mid January. The session recessed at 12:30 p.m.

The Association Tennis Tournament began on Monday, June 20, 1977 and was concluded on Tuesday, June 21, 1977. The Crab Feast and Chicken Dinner at the Berlin Fire Hall was held in the evening followed by TAMPA's square dance and festivities.

Second Day
June 21, 1977

The general session was called to order 9:10 a.m. by President Rubin. His opening remarks included thanks to Stanley J. Yaffe for distributing copies of the Proposed Pharmacy Act Provision to AID Drug Stores.

In the absence of the Secretary of the Board of Pharmacy, Robert E. Snyder, who traditionally presented a necrology of the pharmacists who died in the previous twelve months, the President called upon Executive Director Gruz to conduct the Annual Memorial Service. Mr. Gruz asked all to rise and observe a few moments of silence and meditation in respect to the memory of those pharmacists who served the public and the profession so faithfully for so many years and had passed away.

Convention Chairman Lubman made a number of announcements regarding the program for the balance of the day and the next day.

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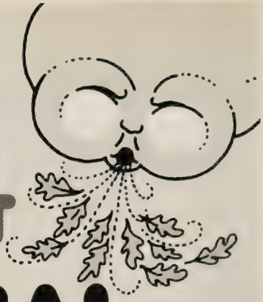

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ADDED SALES BOOSTER: Inside all Robitussin & Robitussin-DM cartons (4 oz. & 8 oz. sizes) a mail-in coupon which entitles customer to 25¢ refund and postage rebate when customer purchases Dimacol® Cold/Cough Capsules.

From the Robitussin® family, the No. 1 brand of cough preparations in drug stores.

A·H·ROBINS A.H. Robins Company, Richmond, Va. 23220

HOUSE OF DELEGATES SESSION

Speaker Morgenroth reconvened the House of Delegates and turned the Chair over to Vice Speaker Lichter.

Continuing Education Committee — Henry G. Seidman, Chairman

The Continuing Education Committee met very early in the year and planned its program for the ensuing ten months. The scheduled programs were presented as arranged by the individual committees to which they were assigned. They were (1) the Simon Solomon Pharmacy Economics Seminar, held on Thursday, November 4, 1976, titled "The Entrepreneur in Pharmacy — Opening, Buying, or Expanding Your Own Pharmacy". Seminar Chairman, Kenneth Sumida. (2) The Robert L. Swain Pharmacy Seminar, held on Thursday, March 17, 1977, titled "Regulatory Agencies and the Pharmacist". Seminar Chairman, Philip H. Cogan.

Both programs were exceptionally well planned and presented. Full details are contained in the individual reports submitted by each of the committee chairmen.

The third program was a series of seven seminars presented at seven different sites in the state in conjunction with meetings of local pharmaceutical associations. The schedule began with the combined meeting of the Maryland Pharmaceutical Association and the Maryland Society of Hospital Pharmacists on January 16, 1977 and continued as follows: February 16, 1977, Upper Bay Pharmaceutical Association; March 10, 1977, Washington County Pharmaceutical Association, Hagerstown; Tuesday, March 29, Allegany-Garrett County Pharmaceutical Association, Cumberland; Wednesday, April 6, Eastern Shore Pharmaceutical Society, Easton; Tuesday, April 12, Prince Georges-Montgomery County Pharmaceutical Association; Tuesday, April 26, Anne Arundel County Pharmaceutical Association, Annapolis. These seminars were co-sponsored by the University of Maryland School of Pharmacy Continuing Education Division. Dr. Ralph Shangraw and Mr. Donald Fedder, School of Pharmacy faculty, presented the programs at each site. Each was of two hours duration.

Other programs were discussed but not prepared for presentation this year.

It is of interest to note that faculty for the continuing education programs of the Maryland Pharmaceutical Association have been readily available for many years because of the advantageous location of the School of Pharmacy next door to the association, and because of the wealth of government agencies within easy travel distance of the MPhA office. The fact that we have constantly enlisted participation of school faculty in our programs, and that we have in many instances been fortunate to enlist government employees to help present our programs has been of great benefit to us in several ways; principally financially.

However, with many changes about to take place affecting the status of providers of continuing education, the provisions required to become a provider, and the costs attached thereto, it will be wise for us to review our position with regard to programming and to determine the best course for us to take. Especially is this true if we are interested in awarding continuing education credits for our programs. The American Council on Pharmaceutical Education has established criteria for quality for evaluating and approving providers of C.E. The criteria have been established to accomplish the following:

1. To provide pharmacists with a dependable basis for selecting approved continuing education experiences,
2. To provide a basis for uniform acceptance of C.E. credits among the states, and
3. To provide feedback of information to providers about their offerings and encourage periodic self-evaluation with a view towards improvement and strengthening of C.E. activities.

I wish to thank President Rubin for the opportunity to serve the Association, and I extend my best wishes to all for a most successful and enjoyable convention.

The report was accepted.

Mr. Lubman moved that the minutes of the spring House of Delegates Meeting of April 21, 1977 be approved as distributed. Motion was seconded and passed.

Constitution and By-Laws Committee — Victor H. Morgenroth, Chairman

Mr. Morgenroth reported that no comments have been received on the version of the amendments of the Constitution and By-Laws presented and adopted at the meeting of April 21. The report was accepted.

Report of Legal Counsel — Joseph S. Kaufman

Mr. Kaufman reviewed a number of decisions which had been litigated in State Court and before the Supreme Court on advertising. He also discussed the Maryland prescription price posting law and announced that the Philip Weiner-Board of Pharmacy case is scheduled to come up June 24, 1977.

After a brief recess, Speaker Morgenroth reconvened the session and called for old business.

1. The first order of business was the Constitution and By-Laws Amendments. On motion of Mr. Gattone, seconded by Mr. Friedman, the amendments as approved at the Spring House of Delegates meeting were adopted.

2. Board of Pharmacy — Mr. Lykos moved that the Association advise the Secretary of Health and Mental Hygiene that the Annual Report of the Board of Pharmacy was not presented, therefore, a copy could not go to the Governor. Seconded and passed.

Mr. Yaffe moved to advise them at the same time as to how the Board is operating, of the inability of the Board to do its work because of lack of funds and staff, and for appropriate action to be taken. Seconded and passed.

New Business

1. Nominating Committee — The report of the Nominating Committee as presented at the previous session was adopted on a motion of S. Ben Friedman, sec-

onded by R. Parker.

2. Board of Pharmacy Nominees — On motion of S. Ben Friedman and seconded by Mr. Parker, the following Board of Nominees were approved for recommendation to the Governor and Secretary of Health and Mental Hygiene:

Anthony Padussis — Timonium
Robert J. Martin — Lavale
Donald Young — St. Michaels

3. The Board of Trustees Report — Henry G. Seidman, Chairman. Mr. Seidman reported the recommendation of David A. Banta of Indiana as Executive Director. On motion of Mr. Friedman, duly seconded, Mr. Banta was approved.

4. Mr. Friedman moved for the appointment of a committee to investigate the hiring practices of pharmacies in Maryland and report to the Board of Trustees, seconded and passed.

5. Mr. Kerpelman moved that Nathan I. Gruz be elected as Executive Director Emeritus, seconded by Kamenetz and passed unanimously.

6. Mr. S. Ben Friedman moved to make election of Executive Director Banta unanimous, seconded by Stanley Yaffe.

7. Mr. Morris Yaffe moved to reconsider the report of the Committee on Nominations, seconded and passed.

8. Mr. Vicino nominated Mr. Morris Yaffe to the second set of nominees for trustee in addition to Messrs. Yousem and Lykos. After the ballot was counted, Messrs. Yousem and Lykos were nominated.

9. Mr. A. Baer moved that court action against the State on Medicaid fees be taken subject to ruling of Association legal counsel. Seconded by Marvin Friedman and passed.

10. **Resolutions Committee** — Joseph U. Dorsch, Chairman.

Resolution #1

BE IT RESOLVED,

That the Maryland Pharmaceutical Association send a letter of thanks and appreciation to Mr. Joseph Cahill, Manager of radio station WCAO, for his kindness and generosity during the past year for providing time for "Your Best Neighbor" program.

Adopted.

Resolution #2

WHEREAS,

The Maryland Pharmaceutical Association is a professional pharmacy organization dedicated to the improvement of health care services and pharmaceutical services to the citizens of the State of Maryland, and

WHEREAS,

In recent years there has been an increasing number of pornographic, obscene magazines, booklets, and paperback books appearing on the shelves of some members of the Maryland Pharmaceutical Association, and

Gantrisin®
sulfisoxazole/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staph. aureus, P. mirabilis, P. vulgaris*). **IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections.** Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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- **Medical Emergency Line**
Remember, too, that information on Gantrisin and all other Roche products is always available to you. The Roche Medical Emergency Line provides a direct, around-the-clock telephone service that can give you immediate answers to your questions. Our information specialists will answer by mail inquiries of lesser urgency. And, as you know, your Roche representative is always ready to serve you.

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WHEREAS,

The display, distribution, and sale of such aforementioned materials are not in the interest of the providing of professional pharmacy services, and are not in the interest of the improvement of the quality of life of the citizens of the State of Maryland, to which the members of the Maryland Pharmaceutical Association are concerned and dedicated,

BE IT RESOLVED,

That the Maryland Pharmaceutical Association condemns such practices and asks its members to refrain now and in the future from the display, distribution, and sale of the aforementioned materials, and

BE IT FURTHER RESOLVED,

That the Public Relations Committee of the Maryland Pharmaceutical Association take the necessary action to inform the citizens of Maryland of this resolution and inform such citizens that it is the wishes of the Maryland Pharmaceutical Association that all pharmacists who are members of the Maryland Pharmaceutical Association will operate their pharmacies as family pharmacies in which any and all members of a family, of any age, or sex, can shop in such pharmacies without being exposed to front-cover picturization of pornographic photographs at check-out counters or any other areas of the pharmacy.

Adopted.

Resolution #3

WHEREAS,

The Maryland Pharmaceutical Association is a professional organization dedicated to the improvement of health care services and pharmaceutical services to the citizens of the State of Maryland, and

WHEREAS,

The members of the Maryland Pharmaceutical Association, as are all other pharmacists and pharmacies in the State of Maryland, are bound by law and regulation to provide only legally approved and legally marketed drugs to the citizens of the State of Maryland, and

WHEREAS,

Certain pharmacies are or may be distributing an illegal drug by the name of Laetrile, and

WHEREAS,

In addition to its illegality, the Federal FDA and scientific research organizations such as the Sloan-Kettering Cancer Center, have stated that Laetrile shows no statistically significant evidence of having curative or preventative benefit, therefore,

BE IT RESOLVED,

That the Maryland Pharmaceutical Association requests the Division of Drug Control to take such immediate action it may deem necessary to prevent this illegal drug, Laetrile, from being dispensed by pharmacy practitioners in the State of Maryland, and

BE IT FURTHER RESOLVED,

That the Public Relations Committee of the Maryland Pharmaceutical Association inform the citizens of the State of Maryland of this resolution and the reasons for it.

Adopted.

11. Ben Friedman moved to congratulate Ronald Lubman, Convention Chairman, for his efforts.

12. Convention Site 1978 — on motion of David Serpick the Carousel Hotel was approved for the convention site of the 1978 Convention.

13. Nominations for Officers of the House — Nominations Committee Chairman Henry Seidman submitted the report: Samuel Lichter for Speaker and Morris Bookoff as Vice Speaker. On motion of Ben Friedman, Milton Sappe was also nominated for Vice Speaker. Mr. Lichter was also elected unanimously as Speaker on the ballot. Mr. Sappe was elected as Vice Speaker.

14. Mr. Stuart Baltimore of Blue Cross requested the floor. He then presented a Certificate of Appreciation from the Board of Directors and Officers of Blue Cross to express their appreciation and thanks to Executive Director Nathan I. Gruz for his services and support rendered Blue Cross. The certificate stated that Mr. Gruz was an instrumental voice during the establishment of the Blue Cross Prescription Drug Program nine years ago.

15. Mr. Lachman moved for the tabling of any action at the convention regarding the proposed revision of the pharmacy act. Seconded and passed.

16. Mr. Gruz moved for the adoption of APhA Report of May, 1971 in regard to a one degree policy for School of Pharmacy.

RECOMMENDATION:

The Committee recommends that the Association adopt the following policy:

1. The Association endorses a single professional degree in pharmacy.
2. The single degree in pharmacy should be a professional doctoral degree.
3. The educational program leading to a single professional doctoral degree in pharmacy should be pharmacy practice oriented.
4. The educational program leading to a single professional doctoral degree in pharmacy should enable a pharmacist to qualify for licensure examination upon graduation and to practice immediately upon successful completion of the licensure examination.
5. The development of standards for the curricula leading to the single professional doctoral degree in pharmacy should involve input from various segments of the profession.

Seconded and passed.

Mr. Seidman moved for unanimous commendation of Mr. Morgenroth's services as Speaker of the House. Seconded and passed.

The 95th Annual Convention of the Maryland Pharmaceutical Association adjourned at 1:00 p.m.

Respectfully submitted,

Nathan I. Gruz
Executive Director

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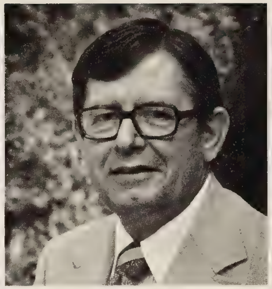
Fred M. Eckel, R.Ph., Assoc.
Professor of Hospital Pharmacy
Chapel Hill, N.C.



Sam McConnell, Jr., R.Ph.
Community Pharmacist
Scottsdale, Arizona

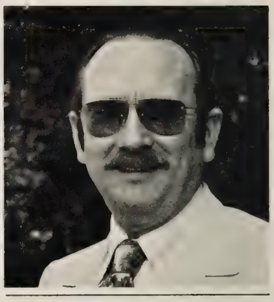
John Spicer, R.Ph.
Community Pharmacist
Fowler, Michigan

Al Rosica, R.Ph.
Community Pharmacist
Cherry Hill, New Jersey

Don F. Gould, R.Ph., Chairman
of the Board, Gould Drug Company
Mt. Pleasant, Michigan

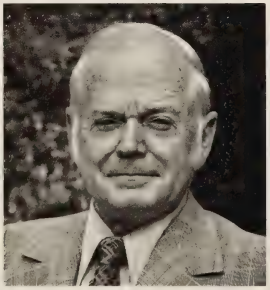
Bill H. Hotaling III, R.Ph. Director
of Pharm. Services, Children's Hosp.
National Medical Center, Wash., D.C.

Newell Hall, R.Ph., V.P. and Director
of Prof. Relations, Hook Drugs, Inc.
Indianapolis, Indiana



Taylor H. Jobe, R.Ph.
Community Pharmacist
Gladewater, Texas

Tom C. Sharp, Jr., R.Ph.
Exec. Sec., Tennessee Pharm. Assoc.
Nashville, Tennessee



Lawrence C. Weaver, Ph.D., Dean
College of Pharm., Univ. of Minnesota
Minneapolis, Minnesota

These days, any company that depends on "yes" men for advice is riding for a fall.

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THE
MARYLAND
PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

AUGUST, 1977
VOL. 53
NO. 8

Maryland Pharmaceutical Association Constitution and By-Laws

Whence Acetaminophen

–John C. Krantz, Jr.

USP Drug Product Problems Report

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
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AUGUST 1977 VOL. 53 NO. 8

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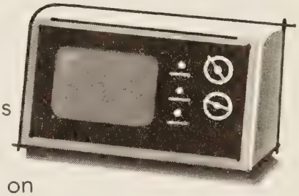

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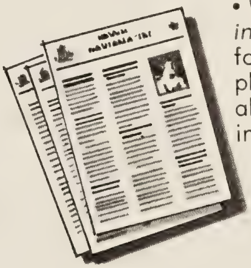

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Third Parties From a Professional View

Third party prescription programs have continued to reach into the pharmacists pocket at an alarming rate. More and more unions and other segments of industy have provided prescription coverage as a part of the Health and Welfare benefit package. This trend has obvious beneficial effect on the health of the covered employee and his family. The unfortunate part of this ever-increasing trend is the failure to recognize the value (and costs) of prescription services. It is easily demonstrated that the product cost component has increased dramatically since the evolution of third-party payment programs. In every case, this increase is recognized and reimbursed to the vendor without question. Similar increased costs of dispensing, coupled with increased services to the patient, have not been given the same consideration for reimbursement. Cost surveys have continually shown the third-party fees to be actually below the costs of such services to the pharmacist.

Another factor adversely affecting the "profit" structure of these plans is the increased prescription size, which according to Dr. John Firestone has increased 56% since 1960.* This is an obvious attempt to "beat the fee" where a co-payment is required. President Raymond Gosselin, Massachusetts College of Pharmacy, views this as a loss of about 900 million prescription fees in 1975 due to the increased Rx quantity.

Viewing the problem in the historical perspective of the pharmacist, the percentage gross profit is at a point below the operating costs of the pharmacy. Unless the insurance programs, and the state, recognize the true costs of dispensing these millions of prescriptions, such services may become no longer available and only the privately paid services will be provided.

As president of the MPhA, I urge each pharmacist to carefully consider all costs in providing services. Be a professional in your work. Demand professional fees that are just and equitable. Support your political action committees. Be informed and active in associations (professional and civic) and vocal with your elected representatives. Only through an informed public and legislature are we going to win the right to negotiate with those to whom we provide professional pharmacy services. Remember, costs are not going down! Fees must go up.

– Richard Parker

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*Drug Topics: April 1977

Maryland Pharmaceutical Association
Constitution and By-Laws

(As amended June 1977)

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Preamble

WHEREAS, to promote progress and to guard the well-being of our profession within the State, Pharmacists should be thoroughly organized, and

WHEREAS, the relations existing between Pharmacists, Chemists, Drug Wholesalers and Manufacturers are, and ought to be, of the most intimate and confidential character, and

WHEREAS, there exists great necessity for the enactment of just, and stringent laws in the interest of the public, to guard against the adulteration, abuse and misrepresentation of drugs and medicines and to confine the compounding and dispensing of drugs and medicines to those who are thoroughly competent and duly licensed. Therefore, be it

RESOLVED, that we, the Pharmacists, Chemists, Drug Wholesalers and Manufacturers of the State of Maryland in convention assembled do hereby organize ourselves into a permanent Association and adopt the following Constitution and By-Laws.

Chapter I — Constitution

ARTICLE I.

This Association shall be known as the MARYLAND PHARMACEUTICAL ASSOCIATION INCORPORATED.

ARTICLE II.

Object of the Association:

The object of this Association is to bring together the reputable Pharmacists, Chemists, and Allied Members of the drug industry of the State, that they may, by thorough organization and united effort, advance the science of Pharmacy, promote scientific research and, in the interest of the public, strive to have enacted just, and stringent laws conforming to state and federal regulations, and to prevent the adulteration, abuse and misrepresentation of drugs and medicines and to confine the compounding and sale of drugs and medicines to duly educated and licensed pharmacists.

ARTICLE III.

Membership:

Section 1. CATEGORIES: This Association shall consist of the following categories of membership:

A. ACTIVE MEMBERS: Any pharmacist of good professional standing and who is a member of the American Pharmaceutical Association, shall be eligible to active membership in this Association, upon subscribing to the Constitution and By-Laws of this Association, and payment of dues for the current year, and shall be entitled to all the rights, privileges and benefits of the Association. For the purpose of the Association Constitution and By-Laws, "pharmacist" shall mean an individual who holds a valid license to practice pharmacy or who holds an earned degree in pharmacy.

B. ASSOCIATE MEMBERS: Any person of an allied profession or calling in the State of Maryland, of good moral character and professional standing, shall be eligible to associate membership in this Association, upon subscribing to the Constitution and By-Laws of this Association and the payment of dues for the current year, and shall be entitled to all the rights, privileges and benefits of the Association except the right to vote or hold office in the Association.

C. AFFILIATE MEMBERSHIP: Any person not a licensed pharmacist in the State of Maryland or others who have a proprietary or managerial interest in a drug store or pharmacy; any owner, members of a corporation or executive of an allied business or calling in the State of Maryland, of good moral character and standing, shall be eligible to affiliate membership in this Association, upon subscribing to the Constitution and By-Laws of this Association, and the payment of dues for the current year, and shall be entitled to all the rights, privileges and benefits of the Association, except the right to vote or hold office in the Association.

D. HONORARY MEMBERS: Professional men, physicians, pharmacists, chemists, scientists and other persons of merit, not actively engaged in the practice of retail pharmacy, shall, upon the vote of 80% of the Board of Trustees, be declared honorary members and shall be entitled to all the privileges of the other classes of members except the right to vote and to hold elective office. They shall not be required to pay annual dues.

E. RETIRED MEMBERS: Any pharmacist who has reached the age of 65 and retired from full-time employment, shall be eligible to retired membership in this Association, upon subscribing to the Constitution and By-Laws of this Association, and payment of dues for the current year, and shall be entitled to all the rights, privileges and benefits of the Association.

F. INACTIVE MEMBERS: Any pharmacist not engaged in full-time employment as a pharmacist or not in a capacity allied to pharmacy or health care shall be eligible to inactive membership in this Association, upon subscribing to the Constitution and By-Laws of this Association, and payment of dues for the current year, and shall be entitled to such rights, privileges and benefits as may be granted by the Board of Trustees, except the right to vote and to hold elective office.

G. NON-RESIDENT MEMBER: Any pharmacist residing and practicing pharmacy outside of the State of Maryland shall be eligible to non-resident membership in this Association, upon subscribing to the Constitution and By-Laws of this Association and payment of dues for the current year, and shall be entitled to such rights, privileges and benefits as may be granted by the Board of Trustees, except the right to vote and to hold elective office.

Section 2. RECIPROCAL MEMBERSHIP: The Association may enter into agreements with such pharmaceutical organizations approved by the Board of Trustees, which are presently or may hereafter be organized within the State of Maryland, for the establishment of reciprocal membership whereby membership in the Association would be a pre-requisite for membership in such other organization and likewise membership in such other organization, for those eligible, would be required for membership in the Association.

Section 3. APPLICATIONS FOR MEMBERSHIP: Applications shall be made on the form prescribed by the Board of Trustees and shall be approved by the vote of a majority of the Board of Trustees.

Section 4. "GRANDFATHER CLAUSE": None of the above qualifications shall change the status of any one who is an active member at this time and who maintains continuous membership in the Association.

ARTICLE IV.

Organization:

The functions of the Association shall be performed by the members through the agency of the House of Delegates, the Board of Trustees or as may be authorized in the Constitution and By-Laws.

ARTICLE V.

Officers and Board of Trustees:

Section 1. The Board of Trustees shall consist of fourteen (14) members which shall include the following officers: President, President-elect, immediate Past President, who shall serve as its Chairman, Vice President, Speaker and Vice Speaker of the House of Delegates, Executive Director (ex-officio without vote), Treasurer, six (6) elected Trustees, one member of the joint SAPhA-MPhA Student Chapter of the University of Maryland School of Pharmacy and two (2) members ex-officio without vote, Dean of the University of Maryland School of Pharmacy and Secretary of the Maryland Board of Pharmacy.

Duties: To act for the Association in the interim between meetings of the House of Delegates, act on applications for membership, ratify appointment of Chairpersons; supervise all property, funds and finances; approve annual budget, appoint the Executive Director with the approval of the House of Delegates; and such other duties as may be specified in the By-Laws.

Section 2. Elected Trustees will serve for staggered three (3) year terms, two elected each year except for the SAPhA-MPhA member who will serve for a term of one year.

Section 3. Election of officers and trustees shall be by mail ballot sixty (60) days after nominations have been certified by the House of Delegates. The results shall be reported to the Board of Trustees by a Board of Canvassers appointed by the President.

Section 4. The Board of Trustees shall meet at the call of the Chairman, President or majority of Trustees.

Section 5. Quorum: Eight (8) members shall constitute a quorum.

Section 6. Vacancies occurring on the Board of Trustees for any reason shall be filled by action of the Board to complete the balance of the term.

Section 7. Removal of Trustee. A Trustee member shall be replaced for sufficient cause by a vote of at least ten (10) members of the Board. Such action may be appealed to the House of Delegates.

ARTICLE VI.

Amendment of Constitution:

Every proposition to alter or amend this Constitution must be submitted in writing to the Constitution and By-Laws Committee. This Committee will prepare the proposed amendment in the proper form and refer it, with its recommendations to the Board of Trustees for discussion and recommendation.

The proposed amendment will be read with the Board of Trustees recommendation at the next duly constituted meeting of the House of Delegates, at which time there may be discussion and revisions of the proposed amendment.

The agreed upon version will then lie over until the next duly constituted meeting of the House of Delegates when, upon receiving an affirmative vote of two-thirds (2/3) of the members present, it shall become part of this Constitution.

ARTICLE VII.

Quorum:

Twenty-five (25) members shall constitute a quorum.

Chapter II — By-Laws

ARTICLE I.

Duties of the President:

The President shall preside over all meetings of this Association; he shall decide all questions of order, subject, however, to an appeal. He shall appoint all committees, unless their appointment is otherwise ordered by the Association and shall be a member of the Board of Trustees and ex-officio a member of each standing committee. He shall present at each annual meeting a report and shall make such suggestions as may seem to him suitable to promote the interest and better carry out the objects for which this Association has been organized. He shall authenticate all proceedings by his signature.

ARTICLE II.

In the absence of the President, or his inability to act, his duties shall devolve upon the Vice President. In the event of the unavailability of the Vice President due to absence or incapacity, another member of the Board of Trustees shall be appointed by the Board of Trustees to serve as President.

ARTICLE III.

Duties of the Executive Director:

The Executive Director shall make and keep correct minutes of the proceedings and conduct all the correspondence of the Association. He shall be ex-officio without vote, a member and Secretary to the Board of Trustees. He shall carefully preserve on file all reports and papers of every description, and it shall be his duty, under direction of the Board of Trustees, to edit "The Maryland Pharmacist", publish and distribute the Proceedings of the Association, countersign all orders upon the Treasury and shall be paid an annual salary of a sum to be determined by the Board of Trustees.

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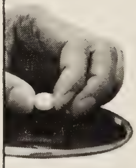

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ARTICLE IV.

Duties of the Treasurer:

The Treasurer shall collect and safely hold all dues and other funds belonging to the Association, to the order of the Board of Trustees. He shall report to the Board of Trustees the status of membership of the Association. He shall at each Board of Trustees meeting render a statement of his accounts showing all income and expenditures. He shall at each annual meeting render a statement of his accounts to the Board of Trustees for audit and report a copy of the same to the Association. He shall be a member of the Board of Trustees. He shall keep a separate account for the monthly journal, charging all expenses and crediting all receipts, setting out this account separately in his annual report. He shall countersign all orders upon the Treasury.

ARTICLE V.

Fiscal Year:

The fiscal year of this Association shall be the calendar year.

ARTICLE VI.

Financial Administration:

Section 1. All checks or orders for payment of money shall be signed by such officer or officers as may, from time to time, be designated by the Board of Trustees, provided such papers be signed by the Treasurer with the approval of the President or such other officer designated by the President.

Section 2. All other contracts, obligations and documents of all kinds shall be executed by the President, whose signature shall be witnessed by the Secretary, after approval shall first have been given by the Board of Trustees or designated by the Board of Trustees.

Section 3. The Board of Trustees shall be empowered to establish dues and assessments for membership in the Association.

Section 4. The Board of Trustees is authorized to allocate a portion of the annual dues for "Kelly Memorial Building Maintenance, Only".

Section 5. Any member, whose dues shall be in arrears as of April 1st of each year shall, after due notification from the Treasurer, lose his rights as a member.

Section 6. The Executive Director and Treasurer shall each receive a salary in such amount as the Board of Trustees may determine for his services.

Section 7. The Finance Committee shall submit an annual budget to the Board of Trustees, which shall submit only a balanced budget to the House of Delegates for approval, and only a balanced budget shall be accepted. This report shall be due sixty (60) days prior to the beginning of the fiscal year.

Section 8. An annual audit shall be prepared by a certified public accountant, who has been approved by the Board of Trustees, at the close of business on December 31st each year. A full and true report of the annual audit shall be given at the annual meeting of the Association.

ARTICLE VII.

Order of Business:

The Board of Trustees shall furnish the order of business for each regular and annual meeting and shall furnish the Executive Director a draft of progress at least thirty (30) days before the date of such meetings.

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Warnings: *Usage in Pregnancy:* The safety of the use of Brethine, brand of terbutaline sulfate, in human pregnancy has not been established. The use of the drug in pregnancy, lactation, or women of childbearing potential requires that the expected therapeutic benefit of the drug be weighed against its possible hazards to the mother or child.

Usage in Pediatrics: Brethine, brand of terbutaline sulfate, tablets are not presently recommended for children below the age of twelve years due to insufficient clinical data in this pediatric group.

Precautions: Brethine, brand of terbutaline sulfate, should be used with caution in patients with diabetes, hypertension, and hyperthyroidism. As with other sympathomimetic bronchodilator agents, Brethine, brand of terbutaline sulfate, should be administered cautiously to cardiac patients, especiall those with associated arrhythmias. Although the con- comitant use of Brethine, brand of terbutaline sulfate with other sympathomimetic agents is not recommended, the use of an aerosol bronchodilator of the adrenergic stimulant type for the relief of an acute bronchospasm is not precluded in patients receiving chronic oral Brethine, brand of terbutaline sulfate, therapy.

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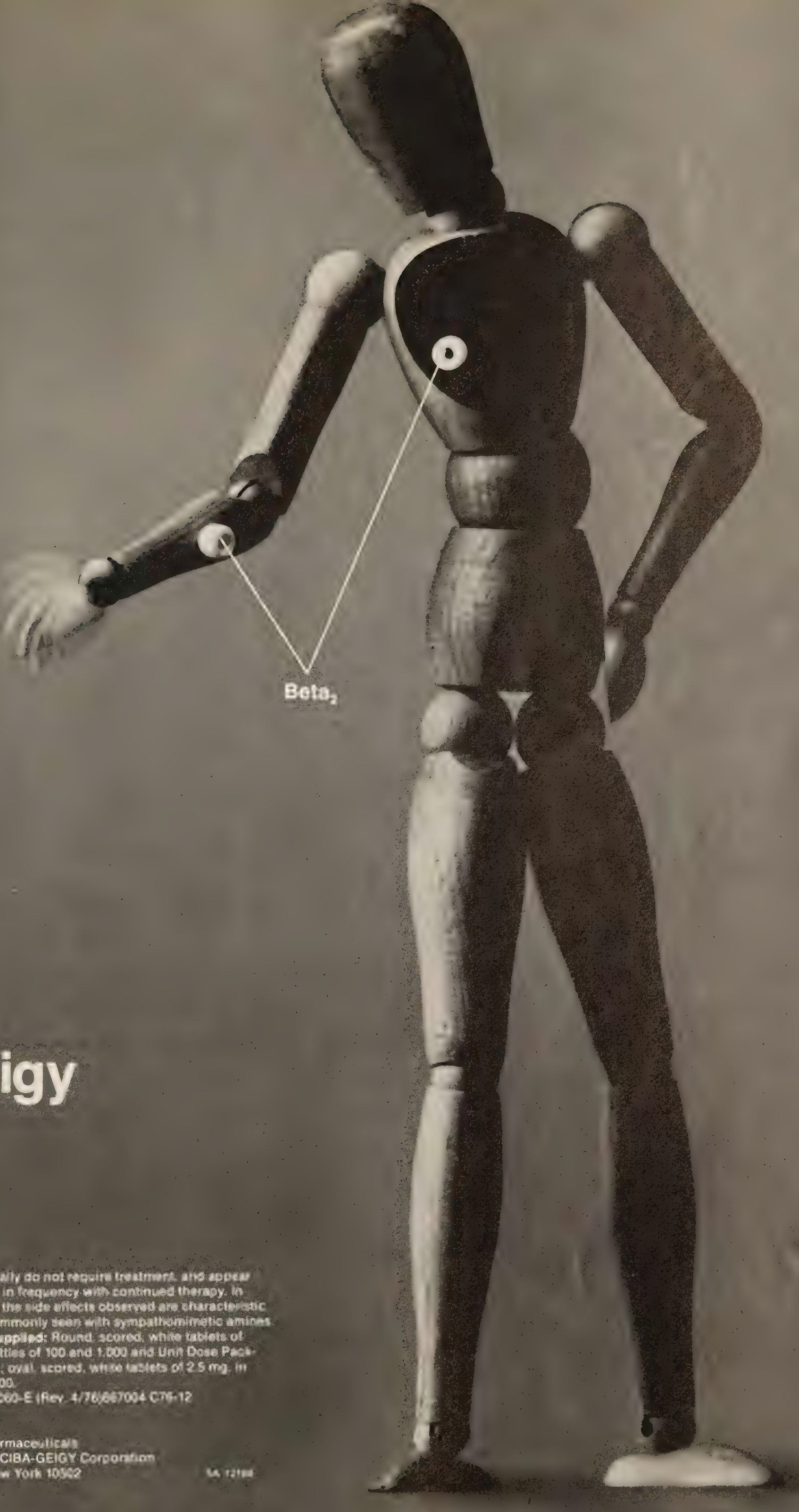

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ture, usually do not require treatment, and appear
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ARTICLE VIII.

Appointment to State Board of Pharmacy:

Section 1. Nomination of pharmacists to the Governor for appointment. A list of members of the profession, in good standing, being skilled and competent pharmacists who have had at least five (5) years' active pharmaceutical experience in compounding and dispensing physicians' prescriptions, shall be submitted by the Nominating Committee of the Association to the Board of Trustees for consideration. The Board of Trustees shall recommend a list of three (3) eligible members, which shall be reported by the Nominating Committee to the House of Delegates at the annual meeting of the Association for confirmation. In conformity with existing state law, the confirmed list of pharmacists shall be submitted for appointment of a pharmacist by the Governor for each vacancy.

ARTICLE IX.

Standing and Special Committees:

The following Standing Committees shall be appointed annually by the President and approved by the Board of Trustees:

1. Professional Affairs
2. Legislative
3. Professional Education
4. Public Affairs
5. Pharmacy Insurance Programs
6. Finance
7. Convention
8. Resolutions
9. Peer Review
10. Judicial Board
11. Nominating
12. Constitution and By-Laws

The President shall also appoint such other special committees as he may, from time to time, deem necessary or advisable. The number of members serving on Standing and Special Committees and the duties and responsibilities of all committees shall be determined by the Board of Trustees and a report of all committees shall be submitted in writing at regular, special or annual meetings of the House of Delegates.

ARTICLE X.

Travelers' Auxiliary:

Section 1. (Authorization) The Maryland Pharmaceutical Association hereby authorizes the organization of the Travelers' Auxiliary of the Maryland Pharmaceutical Association to be a permanent organization to aid in the entertainment of the Association.

Section 2. (Membership) Membership of the Auxiliary shall comprise all representatives who sell to the pharmacists and to the drug trade in general.

Section 3. (Dues) Each member of the Auxiliary shall pay annual dues to the Treasurer of the Auxiliary, in an amount approved by the Auxiliary and the Association.

Section 4. (Function) The Convention Committee of the Maryland Pharmaceutical Association shall devise with the Travelers' Auxiliary in matters pertaining to the program of entertainment for the annual meeting of the Association.

ARTICLE XI.

Ladies Auxiliary:

Section 1. (Authorization) The Maryland Pharmaceutical Association hereby authorizes the organization of the Ladies' Auxiliary of the Maryland Pharmaceutical Association to be a permenent organization to aid in the entertainment of the Association.

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FOTO DATE: AUG., 1975

Dear Mother,
Here's Bobby.
Doesn't he
look just
wonderful.
He's four
now.
Love,
Viki

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New convenience
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double-strength dosage form
for acute cystitis* patients

*nonobstructed, due to susceptible organisms

New Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, nonobstructed cystitis due to susceptible strains of *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris...*

- The same amount of medication, the same efficacy, with only *half* the number of tablets per day.
- Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) STAT—then 1 tablet B.I.D. for 10 to 14 days.
- Clinical efficacy so basic you can start cystitis therapy even before culture results are available.
- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey

and economy

Please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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(July 1-Aug. 29, 1977)

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Robitussin (GUAIFENESIN, NF)
Robitussin
DM
6-8 Hour
COUGH FORMULA
Robitussin-DM
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Buy 'em while it's hot for more cold profit this fall and winter. During 1976 Robitussin-CF® gained 29%, Robitussin-PE® moved ahead 17%, and Robitussin-DM® and Robitussin® were up 10% and 6%, respectively. You know these top sellers will move off your shelves, so stock up extra heavy during this special Deal period and give them plenty of shelf facings. Your Robins Representative will be around soon with all the details.

ADDED SALES BOOSTER: Inside all Robitussin & Robitussin-DM cartons (4 oz. & 8 oz. sizes) a mail-in coupon which entitles customer to 25¢ refund and postage rebate when customer purchases Dimacol® Cold/Cough Capsules.

From the Robitussin® family, the No. 1 brand of cough preparations in drug stores.

A·H·ROBINS A.H. Robins Company, Richmond, Va. 23220

Section 2. (Membership) Membership of the Auxiliary shall comprise the wives of pharmacists, teachers and all representatives who sell to the pharmacists and to the drug trade in general.

Section 3. (Dues) Each member of the Ladies' Auxiliary shall pay annual dues to the Treasurer of the Auxiliary, in an amount approved by the Auxiliary and the Association.

Section 4. (Function) The Convention Committee of the Maryland Pharmaceutical Association shall devise with the Ladies' Auxiliary in matters pertaining to the program of entertainment for its annual meeting of the Association.

ARTICLE XII.

Students' Branch:

Section 1. (Authorization) The Maryland Pharmaceutical Association hereby authorizes the organization of a Joint Students' Branch of the American Pharmaceutical Association and Maryland Pharmaceutical Association.

Section 2. (Membership) Students who are members of the third, fourth and fifth years professional classes, respectively, of the School of Pharmacy of the University of Maryland shall be eligible for active membership in the Joint Students' Branch.

Section 3. The Joint Students' Branch is hereby empowered to adopt a Constitution and By-Laws which Constitution shall be approved by the Maryland Pharmaceutical Association before taking effect.

Section 4. The Joint Students' Branch is empowered to elect such officers and appoint such committees as provided for in the Constitution and By-Laws, including an Executive Committee. The President of the Maryland Pharmaceutical Association shall be a member ex-officio and without vote.

Section 5. The Student Branch is authorized to elect or appoint one(1) member to serve a period of one(1) year on the Board of Trustees of MPhA.

Section 6. The members of the Joint Students' Branch of the American Pharmaceutical Association and Maryland Pharmaceutical Association shall be entitled to receive "The Maryland Pharmacist" for each month of the college year, upon the payment of the Publications Committee of the Maryland Pharmaceutical Association the sum of one ($1.00) dollar per member.

ARTICLE XIII.

Amendment of By-Laws:

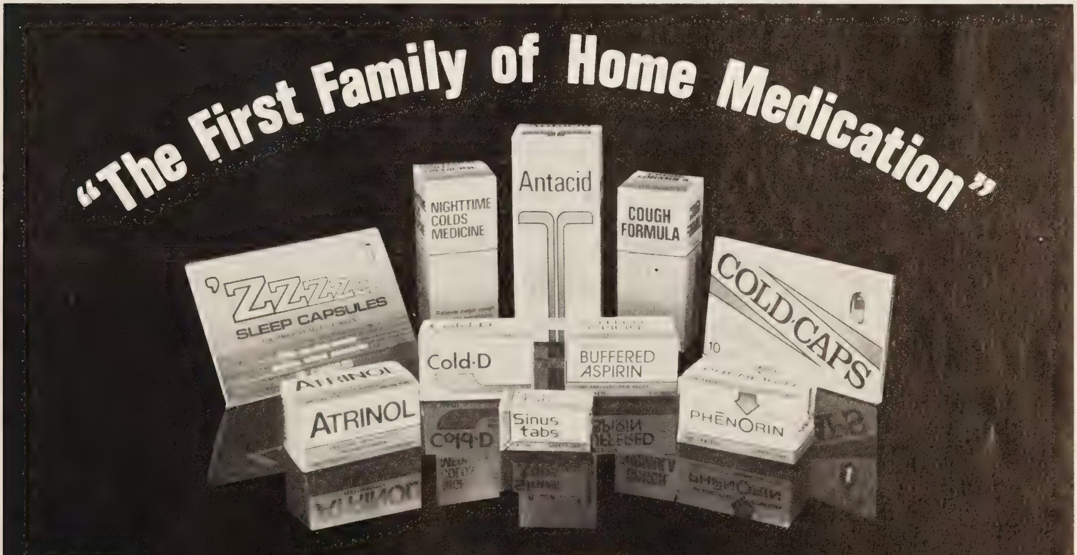
These By-Laws may be amended by the affirmative vote of two-thirds of the members in attendance, at any regular meeting of the members or a special meeting called for that purpose; provided that notice to members, in writing, of the proposed changes be given at least fifteen (15) days before the meeting.

ARTICLE XIV.

Order of Business:

The order of business at the annual meeting and special meetings where appropriate shall be as follows:

1. Call to order
2. Roll Call
3. Reading of Minutes of Previous Meeting
4. Reading of Communications
5. Reports of Officers and Committees
6. Unfinished Business
7. Election of Members
8. New Business including election of Officers and members of the Board of Trustees
9. Adjournment



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ARTICLE XV

Rules of Order:

Roberts Rules of Order shall prevail in the meetings of this Association and House of Delegates.

ARTICLE XVI

House of Delegates

Section 1. (Composition) The House of Delegates shall consist of the officers of the House of Delegates, the Delegates representing affiliated organizations, the Delegates representing recognized organizations, Delegates representing the University of Maryland School of Pharmacy and ex-officio Delegates. Delegates shall be apportioned as follows:

- A. Affiliated Organizations:
  A recognized organization which has entered into an affiliation agreement with the Board of Trustees; Two (2) Delegates, plus one (1) Delegate for each 25 Association members, or major fraction thereof.
- B. Recognized Organizations:
  An organization, the majority of members of which are pharmacists and carry on activities designed to encourage and promote public health and the advancement of pharmacy, may be designated as a recognized organization by the Board of Trustees. The designation as a recognized organization may be terminated by the House of Delegates upon recommendation of the Board of Trustees: One (1) Delegate plus one (1) Delegate for each 50 Maryland Pharmaceutical Association members or major fraction thereof.
- C. The University of Maryland School of Pharmacy:
  - (1) Administration or Faculty, one (1) Delegate
  - (2) Joint APhA-MPhA Student Chapter, one (1) Delegate for each of the three professional years
- D. Officers and the Board of Trustees and the three (3) immediate past presidents of the Maryland Pharmaceutical Association shall be Delegates ex-officio with vote.

Section 2. (Duties of the House of Delegates) The House of Delegates shall be charged with the following duties and responsibilities:

- A. It shall interpret the objectives of the Association.
- B. It shall serve as the legislative and policy-making body.
- C. It shall consider all appropriate proposals eminating from the Board of Trustees, associated sub-divisions, standing and special committees, affiliated organizations, recognized organizations, Delegates, Delegates ex-officio and all local associations.
- D. It shall adopt By-Laws for the conduct of its business which will not be inconsistent with the Association Constitution and By-Laws.
- E. It shall transact all general business of the Association not otherwide specified in the Association Constitution and By-Laws.

Section 3. (Election of Appointment of Delegates)

- A. Delegates and alternates shall be appointed or elected by each sub-division, affiliated or recognized organization for the period from Convention to Convention.
- B. Delegates and alternates must be certified to the Secretary at least 30 days before the annual meeting.
- C. Alternate Delegates not specified in advance are subject to the approval of the House of Delegates.
- D. Delegates Ex-Officio
  The term of office for the Delegates ex-officio shall be for the term of their service in their respective office, unless otherwise specified.

REMINDER

MPhA Dinner Theatre,
Colony 7 Motor Inn
"Man of La Mancha"
September 11

Chapter III — By-Laws of the House of Delegates

ARTICLE I

Officers:

Section 1. (Organization) The officers of the House of Delegates shall consist of a Speaker, a Vice-Speaker and a Secretary. The Association Executive Director shall serve as Secretary to the House of Delegates.

Section 2. (Duties)

- A. The officers of the House of Delegates shall arrange the programs of all meetings of the House of Delegates.
- B. The officers of the House of Delegates in collaboration with the Association Board of Trustees shall delegate recommendations of the House of Delegates to the appropriate officers and committees in order to assure the dissemination of information, policies adopted and their implementation by whatever means may be feasible and desirable.
- C. The Speaker may present an Address at the first session of the yearly meeting of the House of Delegates.

Section 3. (Speaker) The Speaker shall be charged with the following duties and responsibilities:

- A. He shall preside at all meetings of the House of Delegates, except in the case of his absence or on account of inability to preside for any other reason when the Vice-Speaker shall preside.
- B. He shall appoint a Parliamentarian to serve as his advisor on all questions of parliamentary procedure.
- C. He shall appoint a Committee on Nomination for Speaker and Vice Speaker and such special committees of the House of Delegates as may be necessary.
- D. He shall prepare with the assistance of the Secretary the Annual Report of the House of Delegates.
- E. He shall perform the duties specified by the Association By-Laws and the customary and parliamentary duties established by usage.
- F. The Speaker shall be elected once a year by the House of Delegates subsequent to the report of the Committee on Nominations.
- G. The Speaker shall be installed at the final session of the House of Delegates immediately following his election.
- H. The term of office of the Speaker shall be approximately one (1) year beginning with the yearly meeting at which he was installed and terminating with the next yearly meeting or until a successor shall be installed.

Section 4. (Vice Speaker) The Vice Speaker shall be charged with the following duties and responsibilities:

- A. He shall preside at those meetings of the House of Delegates when the Speaker is absent or unable to preside for any other reason.
- B. He shall perform the duties specified in the By-Laws of the Association and the customary and parliamentary duties established by usage.
- C. He shall be elected once a year by the House of Delegates subsequent to the report of the Committee on Nominations.
- D. The Vice Speaker shall be installed at the final session of the yearly meeting of the House of Delegates immediately following his election.
- E. The term of office of the Vice Speaker shall be approximately one (1) year beginning with the yearly meeting at which he was installed and terminating at the next yearly meeting or until his successor shall be installed.
- F. In the event of the inability of both the Speaker and the Vice Speaker to preside, a Temporary Speaker shall be elected by the House of Delegates, except at the opening of the first session of the House when the President shall preside.

Section 5. (Secretary) The Secretary to the House of Delegates shall be the Association Executive Director. Provisions applicable to the Secretary shall be contained in the Association By-Laws dealing with the Executive Director. The Secretary shall be charged with the following duties and responsibilities:

A. He shall read all communications and papers received by the House of Delegates.

B. He shall call and record the aye's and nay's whenever they are required to be called in the House of Delegates elections.

C. He shall notify committees of the House of Delegates of their appointment, stating the business on which respective committees are to act.

D. He shall report the verified credentials to the first session of the House of Delegates.

E. He shall report credentials received and verified after the first session to the next session of the House of Delegates.

F. He shall sumit the Proceedings of the House of Delegates for publication annually. These Proceedings shall also contain a list of officers, committees and members of the House of Delegates.

G. He shall procure a sufficient number of copies of the Proceedings of the House of Delegates for distribution among Delegates and Association officers and on request of Association members.

H. He shall distribute to members of the House of Delegates a brief summary of the proceedings of each meeting of the Board of Trustees within 21 days following the meeting.

I. He shall perform the duties specified in the By-Laws of the House of Delegates and of the Association or otherwise assigned by the House of Delegates.

ARTICLE II

Meetings:

Section 1. (Time)

A. Regular Meeting
The House of Delegates shall meet at the annual meeting of the Association and at the regional meetings; and upon the call of the Speaker, or upon written request of one-fourth (¼) of the voting Delegates.

B. Special Meetings
Special meetings of the House of Delegates may be called between annual meetings at the call of the Speaker, with the consent of the Board of Trustees, or upon written request of one-fourth (¼) of the voting Delegates.

Section 2. (Opening of the House of Delegates) The first session of the yearly meeting of the House of Delegates shall be called to order by the Speaker, the Vice Speaker or the Secretary.

Section 3. (Delegates) After the session of the House of Delegates has been called to order, the Secretary shall record the accredited representatives who shall then compose the House of Delegates.

Section 4. (Voting) Each Delegate shall be entitled to one(1) vote. No Delegate shall act as proxy of another Delegate, nor as Delegate for more than one (1) association or organization.

Section 5. (Privileges) With the exception of executive sessions, Association members may attend any session of the House of Delegates and shall be granted the privileges of the floor.

ARTICLE III

Committees

Section 1. (Standing Committees)

A. Committee on Nominations

(1) The Committee on Nominations shall be responsible for the nomination of candidates for the office of Speaker and Vice-Speaker of the House of Delegates.

(2) It shall present the slate of proposed nominees to the House of Delegates at the annual meeting of the Association; and if approved by the House of Delegates, these nominees shall become candidates for election to their respective offices.

(3) Officers of the Association shall be elected in accordance with the provisions of the Constitution of the Association.

(4) Officers of the House of Delegates shall be elected at the first session of the annual meeting.

Section 2. (Special Committees)

A. The Speaker shall appoint such special committees of the House of Delegates as may be necessary. Special Committees shall consist of a Chairman and four (4) members unless otherwise specified. Special committees shall serve until the end of the next yearly meeting. Each special committee shall submit a report of its activities to the House of Delegates.

ARTICLE IV

Order of Business

The order of business at regular meetings of the House of Delegates shall be as follows unless otherwise determined:

1. Call to order
2. Roll call of Delegates
3. Reading and adopting of the Minutes
4. Appointment of committees
5. Address of the Speaker of the House of Delegates
6. Receipt of reports of officers and committees and other communications from the Association and the Board of Trustees, all of which shall be in writing.
7. Receipt of other reports and communications, all of which shall be in writing.
8. Unfinished business
9. New Business
10. Election of officers

Good and welfare

12. Adjournment

ARTICLE V

Amendments:

Section 1. Amendments to the By-Laws of the House of Delegates shall be submitted in writing at any session of the House of Delegates and may be acted upon at the next session of the House of Delegates, provided that notice to members in writing of the proposed changes be given at least fifteen (15) days prior to the meeting at which the vote is to be taken. Upon affirmative vote of two-thirds (2/3) of the members in attendance at the meeting, the amendment will become part of the House of Delegates By-Laws.

ARTICLE VI

Rules of Order:

The procedure of the House of Delegates shall be governed by Robert's Rules of Order when not in conflict with these By-Laws or with any rules adopted by the House.

ARTICLE VII

Quorum:

Twenty (20) members including at least one officer of the House of Delegates shall constitute a quorum for the transaction of business.

Continued on page 32

USP Drug Product Problems Report

Listed below are case studies which have resulted from the Drug Product Defect Reporting Program.*

These new case studies are intended to help practitioners become aware of problems involved in producing and maintaining high quality in drug products, thereby assisting them in detecting defective products and helping them avoid subjecting drugs to deleterious conditions of storage and handling. No reflection on any specific manufacturer, distributor, pharmacist, or product is intended or should be inferred from the case studies.

A. Incorrect Labeled Potency

A Kentucky hospital pharmacist reported incorrectly labeled aminophylline ampuls on which the strength per cc was printed as 0.25 GM rather than 0.025 g as it should have been. The manufacturer recalled the lot reported by the pharmacist and an additional lot showing the same error.

B. Carton Mixup

A Massachusetts community pharmacist submitted a report that led to a recall by a manufacturer of Bacitracin Ointment. The problem involved a packaging error in which some tubes were put into cartons labeled Boric Acid Ointment. After receipt of the original report, a follow-up inspection on the premises of the own-label distributor revealed seven more similarly mislabeled packages. The recall was initiated when the firm was notified that the antibiotic certificate was revoked in part.

C. Label Mixup

The manufacturer of a pediatric cough preparation recalled its product because of a mislabeling. This error was detected and reported by a California community pharmacist who received a shipment of the pediatric medication that included one bottle labeled as a different preparation in the same family of medications. He became suspicious of the single unit, since its contents resembled that in the other bottles. Laboratory analysis confirmed his observation.

D. Label Mixup

A community pharmacist in Indiana reported finding a bottle labeled as tablets containing anticholinergic drug *with* phenobarbital, but which actually contained only the anticholinergic drug (without the phenobarbital). His observation of a label mixup was confirmed by the manufacturer who agreed to a voluntary recall to the wholesale level.

E. Failure to Meet USP Disintegration Requirements

A voluntary recall to the retail level was initiated by the distributor after enteric-coated ferrous sulfate tablets were reported by a New York hospital pharmacist to have failed dissolution testing. The manufacturer's reserve samples were tested and failed to disintegrate properly, leading to the recall.

F. Voluntary Destruction

A report from a hospital pharmacist in Michigan described an analgesic elixir as containing crystalline material. A FDA follow-up inspection on the report at the firm's facilities revealed that the firm had voluntarily destroyed 972 four-ounce units and 120 sixteen-ounce units of the elixir after confirming the presence of crystals in the reserve sample.

G. Leaking Capsules

Two Drug Product Defect Reports from Michigan pharmacists reporting that capsules of a stool softener were leaking led to an inspection of the repacker of the product. The inspection revealed leaking capsules in the reserve samples. The repacker agreed to a voluntary recall when laboratory testing confirmed the leakage.

H. Thin-walled Bottles

A Minnesota pharmacist reported that he was receiving bottles of an OTC skin cleaner in which the bottles were of very thin plastic and were found to crack, break, and puncture in shipping and handling. The manufacturer responded that he was pleased to be apprised of the situation. He was aware that some of the plastic containers were somewhat lower in weight than met their specifications, and had been rejecting them. The bottles do become somewhat brittle, particularly when subjected to low temperatures. Apparently some of the lower-weight bottles had slipped by. The firm arranged with the supplier to increase the weight of the container, which should reduce the incidence of thin-wall containers

I. Strength Added to Vial Label

A New Jersey hospital pharmacist reported that the concentration of atropine sulfate per ml was stated on the shelf package but not on the individual vial. He noted that many atropine dosages are for less than 1 mg and only a portion of the vial contents are used. He received the following reply from the manufacturer:

"In accordance with your suggestion, we are modi-

Continued on Page 32

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*The work upon which this publication is based was performed pursuant to Contract No. FDA 72-88 with the Public Health Service, Food and Drug Administration, Department of Health, Education, and Welfare.

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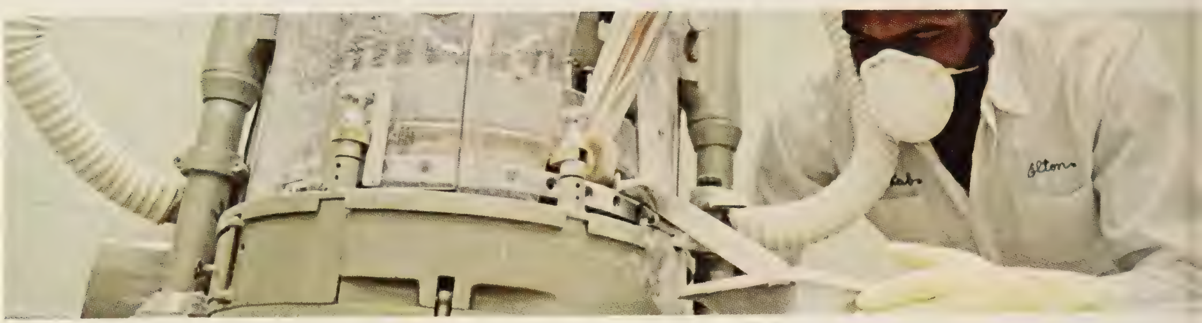

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Detecting the burglar

by Thad L. Weber, Security Consultant, SK&F Laboratories

In preceding columns we noted that burglary is a crime of opportunity which you can prevent by an "I know I can" security attitude, physical barriers and locks that both discourage forced entry and deny the burglar an easy escape route, and alarm systems to deter or detect entry through weak physical barriers such as the ordinary glass in an entrance door, a lightweight party wall, a ceiling or the roof.

Now let's discuss the elements of a burglar alarm system which are suitable and efficient in a pharmacy environment.

The Sensing System

1. Contact Switches.
    a. Devices which detect the entry of an intruder through a movable opening such as a door, window, transom or roof hatch are variously known as alarm contacts, attachments or switches. The most common, least costly device in use is the magnetic switch. A simple magnet is glued or screw-fastened to the *movable* section adjacent to an electric switch attached to the fixed door or window frame. Movement of the magnet an inch or more away from the switch causes the switch to open or close and results in a change in electrical current flow over the wires connecting the switch to the alarm control unit—an alarm condition.
    b. Since windows and doors are the most common point of entry, each such accessible (easily reached from the ground or an adjacent roof) opening should be equipped with an alarm device unless physical penetration of the opening is near to impossible.
2. Protection of Glass.
    a. Panels of window and entrance door glass, which are not listed by Underwriters' Laboratories as burglary-resistant and which are large enough to permit the passage of an intruder, should be "protected" by the use of electrical foil or vibration sensing devices.
    b. If there are many windows, vibration sensing devices may be the less costly approach; however, the physical condition of window frames should first be considered to make certain a high incidence of false alarms is not likely.
3. Interior Traps.
    While the aforementioned devices may be necessary as a deterrent, they will not detect the professional burglar who plans his entry through walls, ceiling or floors. Thus an effective sensing system should include alarm devices which will detect the entry of the intruder (e.g., through a wall) or his subsequent movement inside the premises.
    The efficient selection and placement of such devices is dependent upon an analysis of the individual pharmacy to pinpoint the following:
    - location of drugs
    - location of currency
    - type of containers used to secure drugs or currency
    - locations of high-value inventory (shavers, jewelry, cameras, cigarettes, film, cosmetics, etc.)
    - aisles or corridors most likely to be used by a burglar.

    Once these factors are in "focus," the most appropriate detection devices may be applied:
    a. *Contact switches* may be attached on interior doors separating storage areas from retail areas. Since the burglar entering through a wall in the rear of the premises will most likely pass through such openings, these protected points are highly efficient in a retail premises.
    b. *Cabinet* and *safe doors* utilized for the storage of drugs and currency should also be equipped with contact switches, preferably concealed, where a wood or sheet metal-like enclosure is in use.
    c. *Electrical floor mats,* exposed or concealed under carpeting and located in major aisles, behind high-value showcases in areas where drugs are dispersed, or in front of drug cabinets or safes are also highly effective and low in cost.
4. High-Risk Pharmacies: Interior Protection.
    Some pharmacies stocking large drug supplies, accumulating significant cash deposits, having major appliance or jewelry inventories, etc., may require more extensive interior protection, such as:
    a. *Complete safe or drug cabinet protection* utilizing a proximity or capacitance alarm which is easily installed and senses the "touch" of the burglar against any part of the structure.
    b. *A sound detection system* which "covers" the entire premises and reacts to the sounds of burglary (breaking glass, hammering on walls, speech sounds).
5. A Suggested Course of Action.
    A burglar alarm sensing system should be tailored to the individual pharmacy environment and should be adequate to deter or detect—not overdesigned to suit, for example, a jeweler's needs. To reach this objective, the following steps are suggested:
    a. Seek the advice of your police department crime prevention officer.
    b. Obtain two or more written preliminary proposals from competent alarm contractors.

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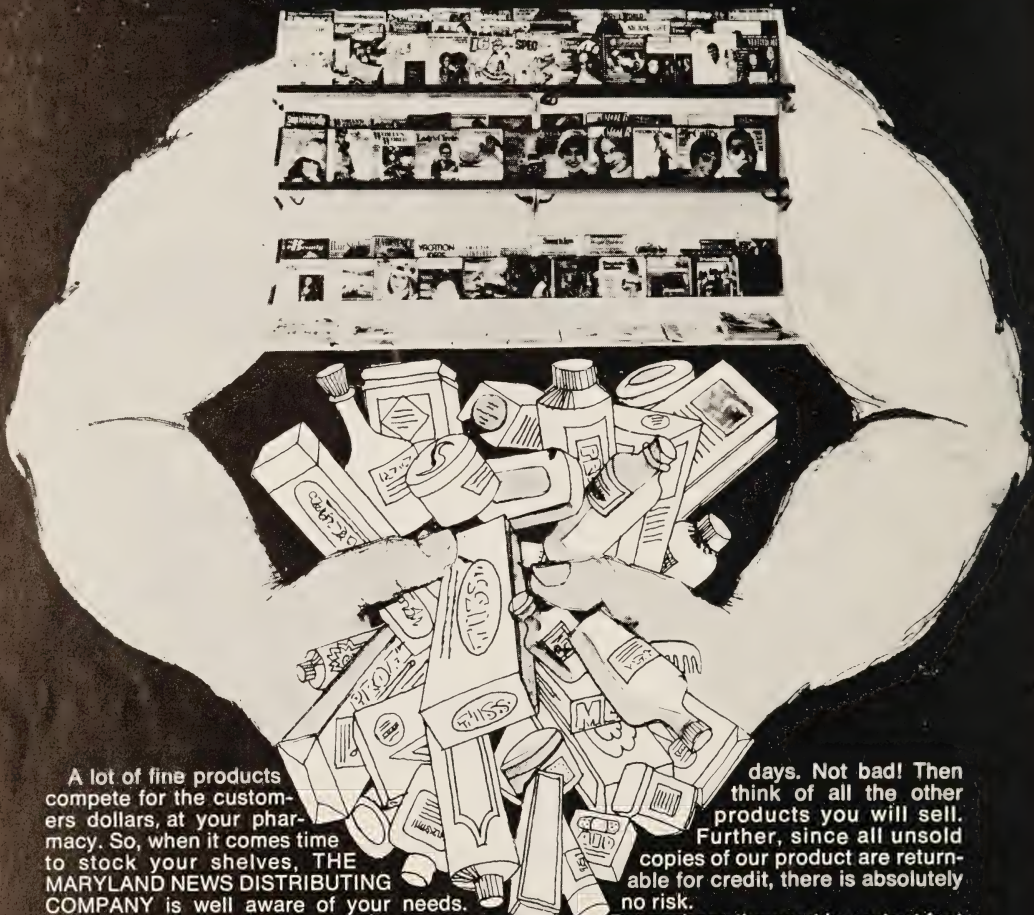
Help Yourshelf...



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Whence Acetaminophen

by John C. Krantz, Jr., Ph.D.*

In September 1882, five months after the death of Charles Darwin, Frederick Woehler died in Gottingen at the age of 82. Darwin's life's work had resurrected out of the fossils of the earth's strata a new order in biology, Woehler had laid the foundation for a new order in every avenue of man's life. He had made an organic compound out of inorganic matter. From ammonium cyanate he made urea in 1828. The Rubicon had been crossed, the chemist was now a creator and every facet of life on the planet would be molded and shaped by this discovery. Medicine was to be on the fore-front as the beneficiary of the new creative laboratories of the organic chemist.

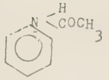
Through the first half of the nineteenth century there were very few analgesic agents available to the medical profession. Wine and opium were extensively used in spite of their deleterious effects upon prolonged use. Salicylic acid obtained from the plant kingdom was available in the form of its sodium salt. From salicylic acid aspirin was synthesized in 1853 but remained as just another organic compound, not of any special interest, until it was introduced into medicine by Felix Hoffman in 1899.

During the latter half of the nineteenth century the German industrial chemical companies were making great strides in the development of new methods to synthesize dyes, explosives and compounds that might be useful as drugs. One of the first of these compounds to be used in medicine as an anti-pyretic and analgesic was acetanilid in 1886.

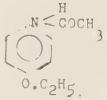
Acetanilid soon became very popular as an over the counter (non-prescription) and also as a prescription drug. It produced few subjective symptoms and the drug was used for prolonged periods by people with recurring neuralgia and muscular pain. The prolonged use of the drug evoked a discoloration of the blood that was shown to be due to met- and sulfhemoglobin. Acetanilid was converted in the body into parahydroxyacetanilid.

To avoid the formation of blood changes, a derivative of the metabolite parahydroxyacetanilid was synthesized by introducing an ethyl group into the molecule of the metabolite as shown by the formulas:

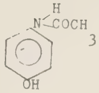
Acetanilid



Acetophenetidin



Acetaminophen



This drug, sold under the name of phenacetin or acetophenetidin, was about equal in analgesia and anti-pyretic potency to its forerunner acetanilid. It is less harmful to the elements of blood. For several decades this drug enjoyed widespread use often admixed with aspirin and caffeine.

Within the last two decades, the attention of the medical profession has been called to many cases of serious kidney damage resulting from the prolonged use of analgesic formulations. Phenacetin was an ingredient in most of these formulations and upon extensive study it was concluded that phenacetin was responsible for the renal damage. The Council on Drugs of the American Medical Association points out that wherever phenacetin has produced kidney damage it has been taken in the form of an analgesic mixture. Nevertheless, warnings must be placed on the package that the drug should not be taken for more than 10 days without consulting a physician.

The discovery of the implication of phenacetin in eliciting kidney damage has drastically reduced its use as an analgesic and as a constituent in analgesic formulations. Meanwhile, the attention of those interested in over the counter analgesics, went again to the metabolite of acetanilid, parahydroxyacetanilid, which was already in limited use under the name acetaminophen in America and paracetamol in England. The first drawback against the use of acetaminophen (APAP) is that although the drug is analgesic and anti-pyretic, it is not antiinflammatory and hence cannot compete with aspirin in arthritis. The third disadvantage is the recent discovery of liver damage caused by the drug when taken in an excessive dose (single dose 7-10 times recommended). Fortunately, there appears to be no collective toxicity produced by the widespread use of the drug. Aspirin still stands out as the drug of choice when evaluated on a benefit-risk scale.

---

*Dr. Krantz is Professor Emeritus, Department of Pharmacology, School of Medicine, University of Maryland.

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THE MARYLAND PHARMACIST

Official Journal of
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SEPTEMBER, 1977
VOL. 53
NO. 9

in the September Issue

Assessment and Treatment of Iron Poisoning

Comprehensive Pharmacy Services at the University of Maryland Hospital

– And More

USP

(Continued from page 23)

fying our individual vial printing plates to indicate potency per ml. These plates should be available for our use within 4 to 6 weeks, and material packaged after that date will carry this additional notation.

"Your kind interest is sincerely appreciated. We wish to thank you again for the time spent in bringing this matter to our attention."

J. **Short Weight Cream**

A California community pharmacist sent in a report on what he considered a misbranded container of a cream commonly used in compounding. He had weighed the contents of a jar that was labeled as one pound and found that it contained 35.4 grams less than the labeled weight. The company responded that the weight had been double-checked before the product left the company and it had been found to have a weight of one pound. The company determined that water evaporation was the cause of the problem, and stated that it had been unaware that water evaporation was resulting in a short-weight situation. The firm's packaging procedures were altered to allow for the evaporation.

K. **Oxidized Levodopa**

Numerous reports were received by the DPDR program concerning a brand of levodopa capsule from a particular lot that appeared dirty, or to have black specks on it. The company wrote to one of the reporting pharmacists explaining that this was apparently oxidized levodopa. As explained by the firm, levodopa converts to a melanin compound upon exposure to moisture. The manufacturing process was described to include polishing the capsules in a moving bed of salt to remove any levodopa from the exterior. Examination of the salt used during the time this lot was manufactured revealed that its moisture content was higher than normal. This, the manufacturer believed, caused minute traces of levodopa to cling to the shell of the capsule and later turn black. The company has initiated procedures to eliminate the cause of the problem.

L. **Hydrochlorothiazide Tablet Friability Specifications Modified**

A California pharmaicst reported hydrochlorothiazide tablets that seemed to be exceptionally fragile, with 25 to 30% of the tablets in a bottle of 1000 capped, chipped, or broken. The company examined both reserve samples and samples obtained from the field. It found that although the file sample satisfactorily passed hardness and friability requirements, the tablets that had been shipped to the field had become more fragile. Test procedures and specifications were modified for the product to insure that batches that meet these specifications will withstand the usual treatment to which they are subject during shipping.

Constitution

(Continued from page 22)

ADDENDUM

Article 43, Section 257, Annotated Code of Maryland, effective July 1, 1976

(A) There is a Maryland Board of Pharmacy, which is part of the Department of Health and Mental Hygiene.

(B) (1) The Board consists of seven members known as Commissioners of Pharmacy.

(2) Of the seven (7) Commissioners (I) six shall be skilled and competent pharmacists, who have had at least five years' active pharmaceutical experience in compounding and dispensing physicians' prescriptions, and of whom at least five are actively engaged in the practice of pharmacy; and (II) one shall be a consumer.

(3) None of the Commissioners shall be connected with any school of pharmacy either as teacher, instructor, or member of the board of trustees.

(4) Two Commissioners shall be residents of the City of Baltimore, two shall be residents of the counties of the State, and three may be residents of either the City of Baltimore or the counties of the State.

(C- The Commissioners shall serve on the Board for a term of five years.

(d) (1) Each professional member of the Board shall be appointed by the Governor, on recommendation of the Secretary of Health and Mental Hygiene from a list of pharmacists of three times the number of vacancies to be filled, submitted by the Maryland Pharmaceutical Association.

(2) Each consumer member of the Board shall be appointed by the Governor, on recommendation of the Secretary of Health and Mental Hygiene.

(E) After notification of his appointment each Commissioner shall subscribe to the oath prescribed by the Constitution of the State of Maryland.

calendar MP

Sept. 8 (Thurs) — Maryland Society Hospital Pharmacists Meeting — Johns Hopkins Hospital

Sept. 11 (Sun) — MPhA Dinner Theatre, Colony 7 Motor Inn. 'Man of La Mancha'

Sept. 20 (Tues) — Alumni Association Meeting

Sept. 27 (Tues) — BMPA Meeting — Pharmacy Law revision

Sept. 29 (Thurs) — State-MPhA Seminar on laws and inspections — Sacred Heart Hospital — Cumberland

Oct. 2-6 — NARD Convention, Washington, D.C.

Oct. 10-18 — MPhA Trip to Rome — limited seats — reservation deadline approaching

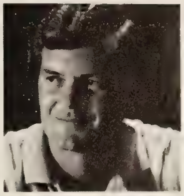
Oct. 27 (Thurs) — MPhA Fall Regional & House of Delegates meeting

Nov. 19 (Tues) — MPhA Simon Solomon Pharmacy Economics Seminar

"Facing" Up to Our Responsibilities

RAY HECKMAN

DENNIS CRAWFORD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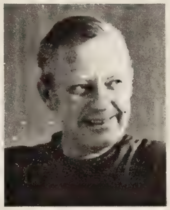
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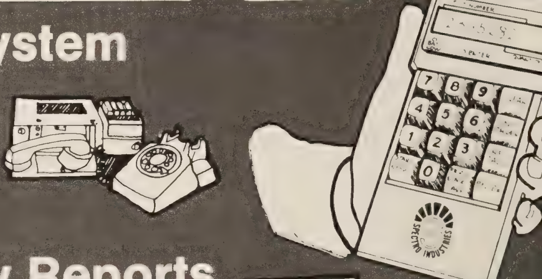

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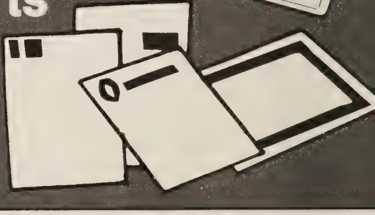

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THE
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SEPTEMBER 1977
VOL 53
NO 9

Assessment and Management of Iron Poisoning

Paul Vitale
Harry Finke, Jr.

Comprehensive Pharmacy Services at the University of Maryland Hospital

Debra V. Naccarto,
V. de Paul Burkhart

Fall Regional and House of Delegates Meeting
Thursday, October 27, 1977

THE MARYLAND PHARMACIST

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SEPTEMBER 1977 **VOL 53** **NO 9**

President's Message

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*Positions assumed at 1977 Convention

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The one the patient takes is never tested.

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But Both Factions Are

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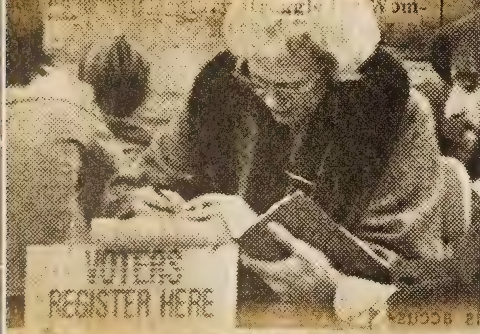

Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14
The Social Security Bill, pr
a broad program of unemp
insurance and old age p
and counted upon to bene
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those chiefly responsible f
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Mr. Roosevelt called the m
"the cornerstone in a st
which is being [illegible]
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SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen o

TRUMAN CLOSES NITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

UL

co

SIGN

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers,* communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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What's All This Talk About Unity?

Do all organizations within the profession have to follow one leader? I say no to that question. Researchers, educators, radio pharmacy specialists, hospital, chain, independent employee, etc., etc., etc. — each group should have a forum in which to advance his own specialized interest and that group should have its autonomy.

On the other hand, all individual pharmacists must belong to the professional organization which represents all pharmacists whatever their field of endeavor. Specifically the APhA and the MPhA must speak for the individual without regard to status.

It is interesting to note the APhA speaks out against polygraph testing, at the same time MPhA expresses feelings against such employee screening practices. Too often we have thought about our differences when discussing items on the agenda of the House of Delegates, Board of Trustees or even at the General Assembly in Annapolis. Let us now pledge to work together for the betterment of the profession and bring to our State the standards of practice and the code of ethics of which we should be proud.

Be an active member of the MPhA. You will find many areas to use your special talents. Contact our Executive Director, Dave Banta, if you would like to serve on a committee. If you have a complaint, bring it out in the open so we can all look at it. My personal belief is that we can accomplish any worthwhile goal if we put our resources to work.

In Maryland, we have approximately 2500 registered pharmacists. With such resources we can and will speak out on all issues which will secure for us a heritage we can be proud to recommend to our children.

Yes, we do need unity, but of people not organizations. Get a friend to join us. Your voice counts.

Summer with MPhA
— *A Pictorial View*

As the summer winds to a close and fall approaches, the energies of MPhA will be directed toward new programs and problems that touch upon the practice of pharmacy. It is enjoyable, though, to pause and reflect on the professional and social activities of the association these past months. Herewith is a brief glimpse of the summer with MPhA.

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William Weiner speaking at the Alumni Association Annual Graduation Banquet.

Melvin Rubin (r.) awarding Victor Morgenroth, Jr. (l.) a gavel for his work as Speaker of the House of Delegates.

Nathan Gruz (r.) presents I. Earl Kerpelman (l.) with the Honorary President of the Board of Trustees Award at the Annual Convention.

(Continued on page 29)

Assessment and Management of Iron Poisoning

by
Paul Vitale*
Harry Finke, Jr., R.Ph.†

Iron preparations today come in many different forms: elixirs, capsules and tablets with some of the tablets resembling a large M & M candy. Many children's chewable vitamin preparations that contain iron are promoted and advertised as tasting like candy. Often, parents pass this information along to their children, unaware of the potential hazard of iron poisoning if too many tablets or capsules are taken. Women often take iron supplement during pregnancy and are not warned about the toxicity if children accidentally ingest a large amount. When the patient brings in a prescription for iron or someone purchases multiple vitamins with iron, the pharmacist should caution the patient about the potential danger of iron poisoning and mention to the parents not to tell their children that vitamins with iron taste like candy. We believe that the pharmacist can play an active and important role in educating the public about iron containing preparations and their toxicities.

Goodman and Gilman reports that the use of iron in the treatment of anemia dates back to ancient times. A Hindu iron medicine known as "Lauha Bhasma" was prepared by roasting sheets of iron and then macerating them to a fine white powder in oil, whey, vinegar, cow's urine and milk. Later, old swords were allowed to rust in drinking water which was then given to patients with marked pallor. In 1861, Sydenham was the first physician to use iron in a manner that would be approved today for treating chlorosis (iron deficiency anemia). Sydenham prescribed "steel in substance" or "iron or steel filings steeped in cold Rehnish wine" with the dose containing from 0.5 to 1.0g of iron daily.[1] In modern medicine the only important use of iron is in the treatment of iron deficiency anemia.

Over the past several years, iron containing preparations have come into widespread use. *The Physicians' Desk Reference* lists more than 113 commercial preparations of iron and the *Handbook of Nonprescription Drugs* lists over 130 iron preparations that can be purchased over-the-counter. A combination of many iron preparations, their wide distribution, easy access and curious children make for all too frequent accidental ingestions. Iron poisoning has become the fourth most common poisoning in children.[1] Acute poisoning from the ingestion of iron salts is more common in children than adults; there are more than 2000 cases annually, with a mortality rate in untreated patients as high as 45%.[2] To help decrease this high mortality rate, it is up to health professionals to educate the public about iron preparations. With prompt recognition in the ER and greater awareness by the medical profession, the morbidity and mortality from iron poisoning could be decreased. If there is any question concerning the treatment of iron poisoning, information is always available 24 hours a day at the Maryland Poison Information Center at 528-7701 locally or 1-800-492-2414 outside Baltimore metropolitan area.

The following hypothetical case illustrates the recognition, diagnosis, treatment and outcome of acute iron poisoning in a child and a discussion of why various treatment methods are utilized.

CASE REPORT

An 18 month old white female weighing 13 kilograms ingested approximately 32 ferrous sulfate tablets each containing 325 mg of ferrous sulfate (2080 mg of elemental iron). About two hours after ingestion the child began having diarrhea and started vomiting. The mother described the vomitus as greenish, containing coffee-ground like material. At this point the mother brought the child to the emergency room. Upon arrival at the emergency room, approximately two and a half hours post-ingestion, the child was vomiting and diarrhea continued and the stool was hematest positive indicating the presence of blood. Blood was drawn for serum iron levels and total iron binding capacity three hours post-ingestion.

Gastric lavage was performed with 1000 ml of a 5% sodium bicarbonate solution utilizing a large bore tube. An abdominal x-ray was taken after lavage which revealed eight radiopaque tablets in the stomach. Gastric lavage was repeated as above, and a second x-ray showed no tablets remaining in the stomach. Gastric aspirate was obtained which showed evidence of blood.

The patient was subsequently admitted to the intensive care unit for observation and evaluation. Several hours post-ingestion, she became lethargic, her skin became cool and clammy and her blood pressure was 60/0 mm Hg by palpation. IV fluids were given for her hypotension. The lab reported a serum iron level of 590 ug/100 ml, and a total iron binding capacity of 504 ug/100 ml (blood obtained three hours post-ingestion). Deferoxamine was given intravenously at a rate of 15 mg/kg/hr for a total dose of 1 gram. The patient's urine became reddish brown 20 minutes after starting deferoxamine therapy, indicating chelation of iron by the deferoxamine.

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†Harry Finke, Jr., is an officer of the Maryland Poison Information Center and is also a practicing community pharmacist.

Eight hours post-ingestion the patient's blood pressure had stabilized at 100/70 mm Hg. At this time the serum iron level and total iron binding capacity were obtained with values of 535 ug/100 ml and 485 ug/100 ml, respectively. Doses of 0.5 grams of deferoxamine were given intramuscularly at 12 hours and 16 hours after ingestion. Twenty hours after ingestion the patient's urine began losing its reddish color, indicating a decrease in the concentration of the excreted chelate, and no further deferoxamine was given.

Blood drawn 16 hours after ingestion showed a serum iron concentration of 310 ug/100 ml and a total iron binding capacity of 490 ug/100 ml.

At 24 hours post-ingestion, the serum iron level was 200 ug/100 ml and IV fluids were stopped. The child was doing well and 24 hours later another serum iron level was done which revealed 150 ug/100 ml. The remainder of the patient's hospital course was uneventful and she was discharged on the fourth hospital day.

On a follow-up visit, 3 weeks following the ingestion, the child presented with bouts of vomiting. Barium contrast studies revealed scarring of the pyloric area of the stomach.

This 18 month-old child represents a clinical problem that has received considerable attention in the pediatric literature over the past 20 years.[4]

Toxicity

While Haddad lists the lethal dose as 300 mg of elemental iron per kilogram of body weight, a serious to potentially lethal dose is considered to be 150 mg/kg and should be treated vigorously.[3] According to Dr. Barry Rumack, editor of *Poisindex*^{R} , death has been reported with 60 mg of elemental iron per kilogram.[6] In a 15 kg child as little as 1.5 grams of ferrous sulfate or about 5 adult tablets may cause toxic symptoms.[4] For this 18 month old child weighing about 13 kg this may mean an ingestion of 2.6 grams of elemental iron, which is an amount present in 40 ferrous sulfate tablets (0.20 x 325 mg = 65 mg of elemental iron/tablet). For salt conversions of other iron salts to elemental iron see the chart at the end of the article.

Correlation between amount ingested and blood levels has not been good. Differences in absorption and unreliability of the history contribute to this discrepancy.[6]

CLINICAL EFFECTS

The clinical features of acute iron poisoning, which are independent of the age of the patient, are delineated into five distinct phases.[5] Phase I occurs anywhere from 30 minutes to two hours after ingestion. Symptoms representing gastrointestinal tract involvement initially present as vomiting, abdominal pain and diarrhea.[1] Iron is a corrosive agent. On direct contact with gastrointestinal mucosa it damages cellular structures and leads to necrosis of gastrointestinal tissue.[1,7,9] There is poor correlation between the severity of toxicity and the extent of damage to the gastrointestinal tract. However, according to Whittner and Brough, in those instances where severe hemorrhagic necrosis occurs, the loss of blood and fluid could contribute to the severity of the shock.[7] Although the mechanism is unknown, absorbed iron through intact gastic mucosa may also cause shock. The 18 month old child in this case entered Phase I about two hours after the ingestion when vomiting and diarrhea began. The vomitus contained coffee-ground like material and the stool was hematest positive. Both are indications that gastrointestinal bleeding is present.

Phase II. In phase II which may last from two to 12 hours, there may seem to be improvement in the patient's clinical condition and the patient may appear to have responded to therapy and recovered.[5] This period of recovery leads to a false sense of security for the physician who is not familiar with iron intoxication.[6] Complete recovery may follow or the third phase may ensue with devastating results.[6] Intensive observation must be maintained during this period.

Phase III begins after the improvement phase (phase II) or may begin two to twelve hours after the first phase.[6] In this phase marked shock and refractory metabolic acidosis may occur. This shock is unquestionably caused by absorbed iron.[7] It is uncertain whether shock is a result of excessive blood and fluid loss through the ulcerated mucosa, or a direct action of absorbed iron on the blood vessels[1], or mediated by the central nervous system[3], or invoked through the production of and release into the circulation of excessive quantities of ferritin (a vaso-depressant possibly released from the damaged mucosa)[7], or due to increased levels of two vasoactive substances, histamine and sero-tonin, demonstrated in experimental iron poisonings in dogs.[4,5,7] Consistent features of shock secondary to iron ingestion are a decrease in cardiac output, increase in total peripheral resistance, decrease in plasma volume, hemoconcentration, decrease in total blood volume and a decrease in blood pressure.[7]

Metabolic acidosis, a consistent feature of experimental poisonings in dogs given lethal doses of iron, may be seen in the third phase. It is probable that metabolic acidosis is a common feature in lethal iron poisoning in children. The extent to which this is true however, is unknown, since only an occasional iron-poisoned child has had his acid-base status determined.[7] Four factors which may contribute to the development of metabolic acidosis are: the release of hydrogen ions due to the

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Such opportunity for interaction will increase in the months and years ahead as more patients come into the treatment system. Because the problem is so tremendous—23 million Americans are hypertensive, yet only half are detected and only an eighth are under adequate treatment—mass screening efforts have been organized throughout the country.

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conversion of iron from its ferric (Fe^{+3}) to ferrous (Fe^{+2}) state;[5] the accumulation of lactic and citric acid from anaerobic metabolism;[1] hypoxia in tissues secondary to shock;[3] and the effect of iron to inhibit or inactivate enzymes of the Krebs cycle.[4,7] After blood work and gastric lavage were done, the patient presented above was admitted for observation and further evaluation. At this time, four hours post-ingestion, the child suddenly experienced cardiovascular collapse and went into shock, entering Phase III.

Phase IV is characterized by hepatic necrosis which occurs about two to four days after the ingestion. The mitochondria of liver cells seems to be the site where iron exerts its direct effect leading to hepatic necrosis.

Phase V usually occurs two to four weeks after ingestion. Patients usually present with bouts of vomiting, and scarring of the pyloris of the stomach is demonstrated by barium contrast studies. This patient did not demonstrate any evidence of hepatic necrosis, however, on a follow-up visit there were symptoms suggestive of gastrointestinal obstruction. Barium contrast studies subsequently revealed pyloric scarring.

LABORATORY

Selection of proper management for acute iron intoxication requires the determination of the presence of free iron. Toxicity usually manifests itself when the serum iron level exceeds the iron-binding capacity of transferrin, the circulating iron-transporting protein.[8] To aid in clinical evaluation of acute iron toxicity the important procedures necessary are emergency serum iron levels and total iron binding capacity values.[1] A child with an initial serum iron level of 500 ug% or greater is generally considered toxic and usually exceeds the total iron binding capacity.[1] Blood samples should be obtained before chelation therapy is begun.

TREATMENT

If a patient presents in a state of shock, as in phase I or phase III, life support measures are required. Shock should be corrected with the proper fluids and electrolytes and whole blood.[6] The patient should be checked for hypoglycemia and respiratory support should be provided as needed.[6] Next, removal of the iron is a primary concern. If early aggressive action is taken to remove iron from the gastorintestinal tract, the severity of poisoning may be reduced.[1, 3, 5] Removal of iron can be achieved by inducing emesis, either by oral administration of syrup of ipecac or parenteral administration of apomorphine.[4] Emesis should be performed unless the patient is convulsing, comatose, vomiting or in phase one presenting with hematemeisis, abdominal pain or diarrhea.[6]

In children, one year of age or older, syrup of ipecac is given orally, as a 15 ml (one TABLEspoonful) dose followed by six to eight ounces of fluid. (Milk may inter-

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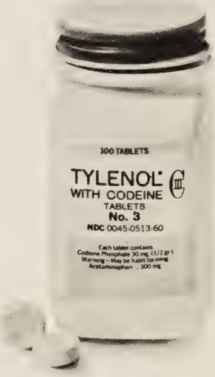

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Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents.
Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.
Precautions: *Head injury and increased intracranial pressure:* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting; more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.
Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.
For information on symptoms and treatment of overdosage, see full prescribing information.

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fere with emesis)[11] Vomiting should take place within 15 to 20 minutes. If vomiting has not occurred after 20 minutes, the initial dose of ipecac should be repeated followed by additional fluid. The maximum total dose of ipecac is 30 ml. Administering syrup of ipecac to children less than one year of age is not recommended unless under medical supervision.

In the case of this 18 month old child, syrup of ipecac was not administered since she had already been vomiting when she arrived at the emergency room. At this point gastric lavage was chosen to help remove the iron and decrease its absorption.

It is felt that gastric lavage should be performed regardless of whether the child has vomited.[4] When performing gastric lavage, in cases of iron poisonings, the largest bore tube that can be passed with ease should be used. Proper lavage fluids used in iron poisonings include a 1:4 solution of a Fleet[R] phosphosoda enema which contains sodium biphosphate. The solution will combine with the ingested iron and form a non-absorbable iron phosphate complex. A 5% sodium bicarbonate lavage solution which forms non-absorbable ferrous carbonate can also be used. Deferoxamine lavage may also be used utilizing a solution containing 5000 mg of deferoxamine/liter. However, deferoxamine is very expensive and the chelate formed with the iron is absorbed from the stomach but iron remains complexed and is probably non-toxic.[6]

In some instances the sodium biphosphate or sodium bicarbonate solution can be given to patients orally before emesis. This should then be followed by a dose of ipecac to induce vomiting.[5] However, if induction of emesis is contraindicated, then gastric lavage is the treatment of choice.

Because iron is radiopaque, an x-ray of the abdomen should be taken after either emesis or lavage to evaluate the degree of iron removal.[5] If iron is seen in the stomach, emesis or lavage should be repeated. Another abdominal x-ray should follow.[1]

Lavage was performed on the child presented in this case utilizing a 5% sodium bicarbonate solution. Lavage was carried out twice because an abdominal x-ray after the first lavage showed eight iron tablets remaining in the stomach. After the second lavage a subsequent abdominal x-ray showed no evidence of iron tablets in the stomach or small intestine. At this point the patient was admitted to the hospital where she was treated with fluids for her hypotensive episode. Laboratory tests indicated the presence of free iron, and chelation therapy with deferoxamine was begun.

Iron is tenaciously conserved in the body, and only minimal amounts of iron are excreted daily.[10] There are two ways of increasing iron excretion: phlebating (taking blood from the patient to decrease the iron level) and the use of certain chelating agents.[8] A chelating agent forms a stable complex with a metallic element. This complex

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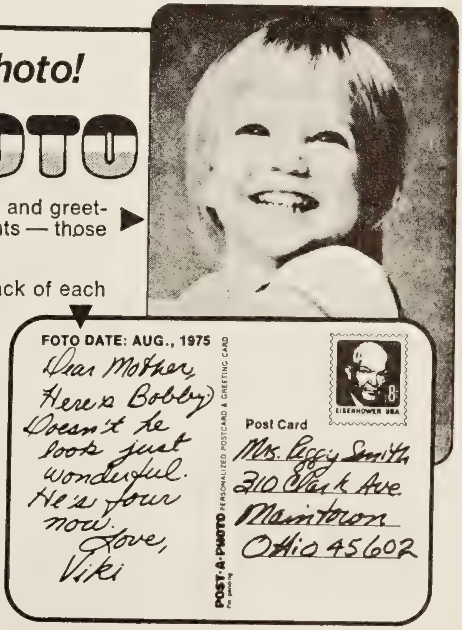

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may be water soluble and excretion through the kidney is enhanced.[4,8] Deferoxamine mesylate (Desferal[R]) complexes with iron to form a stable complex which is readily soluble in water. This complex is called ferrioxamine and can pass through the kidney easily.[4,8] Because of the enhanced excretion of ferrioxamine through the kidney, parenteral chelation therapy with deferoxamine is an important aspect in the management and treatment of an acute iron poisoning.[4,8]

In a patient not in shock, deferoxamine should be administered intramuscularly given as a 1 gram dose initially, followed by 0.5 grams every four hours for two doses. The injections of 0.5 grams may be continued at four or 12 hour intervals, depending on the clinical response, but the total amount of drug administered should not exceed 6 grams in 24 hours.[8] Deferoxamine administration intravenously is required for patients in shock. The dosage schedule and limitations are the same as those recommended for intramuscular administration. However, *the infusion rate must never exceed 15 mg/kg per hour.* As soon as the clinical situation permits (i.e., patient no longer in state of cardiovascular collapse), intravenous administration of deferoxamine should be halted and the drug given intramuscularly.[10] The presence of the chelated ferrioxamine in the urine imparts a red, "vin rose" color to the urine. When this color is no longer seen in the urine, this indicates that the free unbound iron has been excreted, and there is a decrease in the concentration of the excreted ferrioxamine complex. At this point chelation therapy can be terminated. However, a better method for monitoring is with serial serum iron levels.

The adverse effects to properly administered parenteral deferoxamine are rare. However, a number of cases of hypotension developing after rapid administration of deferoxamine intravenously have been reported. Hypotension is not seen where deferoxamine is given at a rate no greater than 15 mg/kg per hour. When deferoxamine is given intravenously, blood pressure should be closely monitored for hypotension. Other adverse effects include rashes and cataracts, which are seen only after chronic use.

Since free iron is not dialyzable, dialysis is of no value. Exchange transfusion is many times more effective in removing iron from the body. This method is of particular importance in removal of excess iron in a child with renal shutdown.

With the evidence of shock in this child, deferoxamine was elected to be initially administered intravenously. Fluid therapy stabilized the patient and she became normotensive enabling a switchover to intramuscular administration of deferoxamine if needed. After two additional intramuscular doses of deferoxamine, the patient's urine began losing the characteristic color, and the serum iron value was such to indicate that free iron was no longer present and chelation therapy at this point was discontinued. The patient recovered because of an alert emergency room staff and proper treatment of an overdose of iron.

If an iron poisoning should ever occur, time is one of the most important factors and the sooner the toxic substances can be removed the less chance there is of the person having a toxic reaction.

Syrup of ipecac is the recommended emetic to be used in the home and if at all possible should be kept in the house especially if there are small children around. The pharmacist can play a vital role as an information source to his patients, especially those with young children, about the use of ipecac, administration and shelf life. And remember, before ipecac is administered by anyone other than a physician call the Maryland Poison Information Center to receive proper instructions and to make sure that ipecac is the proper treatment for the substance ingested.

We would like to thank Gary Oderda, Pharm.D. and Wendy Schwartz, Pharm.D. for their technical advice, Jacquie Lucy for editing and Annette Byers for typing.

Reference Chart listing commercially available iron preparations and their concentration of iron can be found on page 16-17.

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IRON PREPARATIONS

Product	Manufacturer	Iron — mg
Abdol c̄ Minerals	Parke-Davis	15 mg as Sulfate
Adabee c̄ Minerals	Robins	15 mg
Aprisac	North American	75 mg as Pyrophosphate
AVP Natal	AVP	66 mg as Fumarate
Beta-Vite w/Iron Liquid	North American	75 mg as Pyrophosphate
B-Nutron	Nion	8 mg as Gluconate
Calcicaps c̄ Iron	Nion	46 mg as Gluconate
Cal Prenal	North American	50 mg as Fumarate
Cebetinic	Upjohn	38 mg as Gluconate
Chocks Bugs Bunny Plus Iron	Miles	18 mg
Chocks Plus Iron	Miles	18 mg
Dayalets Plus Iron	Abbott	18 mg
Engran-HP	Squibb	18 mg
Feminaid	Nion	18 mg
Feminins	Mead-Johnson	18 mg
Femiron c Vitamins	J. B. Williams	20 mg as Fumarate
Ferritrinsic	Upjohn	60 mg as Sulfate
Ferrolip Plus	Flint	28 mg as Ferrocholinate
Filibon Capsules	Lederle	30 mg as Fumarate
Filibon OT Tablets	Lederle	30 mg as Fumarate
Flintstones Plus Iron	Miles	18 mg
Geriamic	North American	50 mg
Gerilets	Abbott	27 mg
Geriplex	Parke-Davis	30 mg as Sulfate
Geriplex-FS Kapseals	Parke-Davis	30 mg as Sulfate
Geriplex-FS Liquid	Parke-Davis	15 mg as Ammonium Citrate/30 ml*
Geritinic	Geriatric Pharmaceutical	35 mg as Ammonium Citrate
Geritol Junior Liquid	J. B. Williams	15 mg as Ammonium Citrate/5 ml
Geritol Junior Tablets	J. B. Williams	25 mg as Sulfate
Geritol Liquid	J. B. Williams	15 mg as Ammonium Citrate/5 ml
Geritol Tablets	J. B. Williams	10 mg as Sulfate
Gerix Elixir	Abbott	15 mg
Gerizyme	Upjohn	5 mg as Gluconate/15 ml*
Gevrabon	Lederle	20 mg/30 ml*
Gevral T Capsules	Lederle	15 mg as Fumarate
Gevrite	Lederle	10 mg as Fumarate
Golden Bounty Multivit Supp. c Iron	Squibb	18 mg
Iberet	Abbott	105 mg
Iberet-500	Abbott	105 mg
Iberet Oral Solution	Abbott	25 mg/5 ml
Iberet-500 Oral Solution	Abbott	16 mg/5 ml
Iberol	Abbott	105 mg
Incremin c̄ Iron Syrup	Lederle	30 mg/5 ml as Pyrophosphate
Liquid Geritonic	Geriatric Pharmaceutical	63 mg/5 ml as Sulfate
Livitamin Capsules	Beecham Labs	33 mg as Fumarate
Livitamin Chewables	Beecham Labs	17 mg as Fumarate
Livitamin Liquid	Beecham Labs	36 mg/15 ml
Lofenalac	Mead Johnson	12 mg
Mol-Iron Capsules	Schering	143 mg as Sulfate
Monster Vitamins & Iron	Bristol-Myers	12 mg as Fumarate
Multiple Vitamins & Iron	North American	15 mg as Fumarate
Multivit Suppl. c Iron	Fisons	18 mg as Fumarate
Myadec Tab. & Caps.	Parke-Davis	20 mg as Sulfate
NAP Tabs	North American	30 mg as Fumarate
Natabec	Parke-Davis	55 mg as Sulfate
Natabec F.A.	Parke-Davis	55 mg as Sulfate
Natalins Tablets	Mead-Johnson	45 mg
Natural Theratab	North American	50 mg as Gluconate
Norimex-plus Capsules	North American	3 mg
Obron-6	Pfipharmecs	35 mg
One-a-Day plus Iron	Miles	18 mg
One-a-Day Vit. Plus Minerals	Miles	18 mg
Optilets-M-500	Abbott	20 mg
Ostrex Tonic Tablets	Commerce	84 mg as Sulfate
Paladac c̄ Minerals	Parke-Davis	5 mg as Phosphate
Peritinic	Lederle	100 mg as Fumarate
Poly Vi Sol c̄ Iron	Mead Johnson	12 mg
Simron Plus	Merrell-National	11 mg as Gluconate
S.S.S. Tonic	S.S.S.	15 mg/15 ml as Ammonium Citrate
Stuart Formula	Stuart	18 mg
Stuart Formula Liquid	Stuart	5 mg/5 ml as Sulfate
Stuart Hematinic	Stuart	22 mg as Fumarate
Stuart Hematinic Liquid	Stuart	22 mg/5 ml as Gluconate
Stuartinic	Stuart	100 mg as Fumarate
Stuart Prenatal Formula	Stuart	60 mg as Fumarate

Product	Manufacturer	Iron — mg
Theragran-M	Squibb	12 mg
Theron	Stuart	15 mg as Fumarate
Tri-Vi-Sol c̄ Iron Drops	Mead-Johnson	10 mg
Unicap Therapeutic	Upjohn	10 mg as Sulfate
Venthera	Amfre-Grant	15 mg as Fumarate
Vigran plus Iron	Squibb	27 mg
Vi-Syneral One-Caps	Fisons	18 mg as Sulfate
Vitagett	North American	13 mg as Sulfate
Vita-Kaps-M Tablets	Abbott	10 mg
Vitamin-Mineral Capsules	North American	13 mg as Sulfate
Viterra	Pfipharmecs	10 mg
Viterra 100% RDA + Iron	Pfipharmecs	18 mg
Viterra Therapeutics	Pfipharmecs	10 mg
VM Preparation	Roberts	50 mg
Zymalixir Syrup	Upjohn	15 mg/5 ml as Gluconate
Zymatinic Drops	Upjohn	5 mg/0.6 ml as Gluconate

Hematinics	Manufacturer	Iron mg	Elemental Iron
Arne Timesules	Haag	150 mg ferrous sulfate	30 mg
Cefera	Haag	200 mg ferrous fumarate	66 mg
Chel-Iron Liquid & Tabs.	Kinney	417 mg/5 ml; 330 mg/tab.	50 mg/5 ml; 40 mg
Chel-Iron Pediatric Drops	Kinney	208 mg/ml ferrocholinate	25 mg
C-Ron	Rowell	200 mg ferrous fumarate	66 mg
C-Ron Forte	Rowell	200 mg ferrous fumarate	66 mg
Dical-D-Iron Caps.	Abbott	10 mg	10 mg
Feosol Spansules	SKF	167 mg ferrous sulfate	33 mg
Feosol Tabs.	SKF	200 mg	60 mg
Ferancee	Stuart	67 mg ferrous fumarate	67 mg
Ferancee-HP	Stuart	330 mg ferrous fumarate	100 mg
Fergon Caps.	Breon	435 mg ferrous gluconate	52 mg
Fergon Tabs.	Breon	320 mg ferrous gluconate	38 mg
Fergon & C Caplets	Breon	450 mg ferrous gluconate	54 mg
Fer in Sol Drops	Mead-Johnson	75 mg/0.6 ml ferrous sulfate	37.5 mg/ml
Fer in Sol Syrup	Mead-Johnson	150 mg/5 ml ferrous sulfate	45 mg/5 ml
Fer in Sol Caps.	Mead-Johnson	190 mg ferrous sulfate	38 mg
Fermalox Tabs.	Rorer	200 mg ferrous sulfate	40 mg
Ferrograd-500 tabs.	Abbott	105 mg	105 mg
Fero-Gradumet Tab.	Abbott	105 mg	105 mg
Ferrater Liver Conc.	Fougera	233 mg ferrous sulfate	46 mg
Ferrobid	Meyer	225 mg ferrous fumarate	74 mg
Ferrolip Tab.	Flint	333 mg ferrocholinate	40 mg
Ferrolip Syrup	Flint	417 mg/5 ml ferrocholinate	50 mg/5 ml
Ferro Mandets	Lederle	60 mg ferrous fumarate	60 mg
Ferronord	Cooper	fe-roglycine sulfate complex	40 mg
Ferro Sequels	Lederle	150 mg ferrous fumarate	50 mg
Fuma Drops	North American	100 mg/5 ml ferrous fumarate	33 mg/5 ml
Fumaral Elixir	North American	325 mg/10 ml ferrous sulfate	*65 mg/10 ml
Fumaral Spancaps	North American	330 mg ferrous fumarate	109 mg
Hytinic Caps.	Hyrex	150 mg polysaccharide Fe Comp.	150 mg
Hytinic Elixir	Hyrex	100 mg/5 ml polysaccharide Fe Comp.	*100 mg/5 ml
Iron & Vit. C	Squibb	50 mg	50 mg
Ironized Yeast	Glenbrook	341 mg/6 tabs. fer. sulfate	68 mg/6 tabs.
Laud-Iron	Amfre-Grant	324 mg ferrous fumarate	107 mg
Laud-Iron Elixir	Amfre-Grant	100 mg/5 ml fer. fumarate	100 mg/5 ml
Laud-Iron Plus Chew. Tab.	Amfre-Grant	100 mg ferrous fumarate	100 mg
L-Glutavite Caps.	Cooper	16%	1.7 mg
L-Glutavite Powder	Cooper	16%	1.7 mg
Mol Iron Liqu.	Schering	195 mg/4 ml fer. sulfate	*39 mg/5 ml
Mol Iron Tabs.	Schering	195 & 390 mg fer. sulfate	39 & 78 mg
Mol Iron & Vit. C	Schering	195 & 390 mg fer. sulfate	39 & 78 mg
Niferex Elixir	Central Pharmacal	100 mg/5 ml	*100 mg
Niferex Caps. & Tab.	Central Pharmacal	150 mg/cap.; 50 mg/tab.	50 mg/tab
Niferex C Vit. C	Central Pharmacal	50 mg polysaccharide comp.	50 mg
Recoup Tab.	Lederle	150 mg ferrous fumarate	50 mg
Simron Caps.	Merrell-Natl.	85 mg ferrous gluconate	85 mg
Toleron Susp.	Mallinckrodt	100 mg/5 ml fer. fumarate	33 mg/5 ml
Toleron Tabs.	Mallinckrodt	200 mg ferrous fumarate	66 mg
Tri-Tinic Caps.	North American	110 mg ferrous fumarate	36 mg
Vitron-C	Fisons	200 mg ferrous fumarate	66 mg

***These products have 4% or greater concentration of alcohol which may be a potential hazard in an overdose in young children.**

Table of Iron Salts and % of Elemental Iron Contained in the Salts

Iron Salts	Unit Strength		% of Elemental Iron		mg of Elemental Iron
Ferrous Fumarate	325 mg	×	30%	=	97.5 mg
Ferrous Gluconate	320 mg	×	12%	=	38.4 mg
Ferrous Sulfate	325 mg	×	20%	=	65.0 mg

Toxic dose is considered to be greater than 60 mg/kg of Elemental Iron.[6]

Comprehensive Pharmacy Services at the University of Maryland Hospital

by

Debra V. Naccarto, B.S.*
V. de Paul Burkhart, M.S.†

Pharmacists at the University of Maryland Hospital are continually increasing their direct involvement in providing quality pharmaceutical services and improving communication with patients and other health care professionals. With the advent of new programs and services developed in the pharmacy, such as centralized pharmacies, sterile and non-sterile support services, extensive technician utilization and a drug information center, the pharmacist is more available to react to patient-related activities. The purpose of this article is to give an overview of these services and show how they combine to provide a comprehensive approach to pharmacy practice in a large teaching hospital.

The University of Maryland Hospital is a state-controlled university-affiliated inner city hospital. It is presently licensed for 924 beds and offers extensive inpatient and ambulatory services. The Hospital, in addition to providing extensive inpatient and ambulatory patient care, serves as the principle facility for the University's various professional schools providing the clinical experience for medical, nursing and pharmacy students. The Hospital's physical plant consists of the South Hospital, which was built in the early 1940's, the Psychiatric Institute, the Maryland Institute for Emergency Medicine (MIEM), and the North Hospital, which was added in the spring of 1973 (Fig. 1).

Before the completion of the North Hospital, the pharmacy was located in the basement of the South Hospital and occupied approximately 1400 square feet. Today, the Department of Pharmacy Services has expanded to more than six times its original size and is located in several different areas of the Hospital. On the first floor of the North Hospital is the Central Unit Dose Pharmacy (C.U.D.), the I.V. Admixture Laboratory, the Ambulatory Pharmacy, the Manufacturing and Dose Preparation Areas, and the Administrative Offices. Located on the third, eleventh and twelfth floors are three satellite or Patient Care Pharmacies (P.C.P.'s), which encompass approximately 140 square feet each and provide pharmacy services in the patient care areas. The previous pharmacy space in the South Hospital has been retained for the Department's quality purchasing program and the storage of drugs and pharmaceutical supplies.

Decentralization of the pharmacy services required an organization structure that also decentralized authority and responsibility relative to supervision of each area (Fig. 2 and 3). Currently, there are seven supervisors (Chairmen), one for each service area of the Department. It should be noted that there is an Associate Director who is reponsible for professional affairs and an Administrative Assistant responsible for administrative affairs (personnel and fiscal). There are also two Assistant Directors. One Assistant Director's duties include all purchasing and procurement of drugs and pharmaceutical supplies; the other oversees all education activities for the Department.

The Department offers a total unit dose drug distribution system provided on both a centralized and decentralized basis. Currently, 60 percent of the Department is decentralized utilizing the three previously mentioned satellites. A fourth satellite is scheduled to open in the near future which will then decentralize 80 percent of the service. The Department, supported by management engineering studies, is moving toward total decentralization to overcome logistical and communication problems.

In addition to providing service, the Department is responsible for education and research. The educational aspects include the undergraduate externship program (Professional Experience Program) with the School of Pharmacy, a joint Master of Science/Residency Program in Institutional Pharmacy, a Technician Training Program and Staff Development.

The Masters Degree/Residency is a 24 month postgraduate program established to train practitioners to provide expanded institutional pharmacy services. Residents become familiar with Hospital Pharmacy practice and conduct research concerning implementation of new programs, emphasizing cost-effectiveness and proper personnel utilization. The Residency is accredited by the American Society of Hospital Pharmacists and the Director of Pharmacy Services is preceptor for this program.

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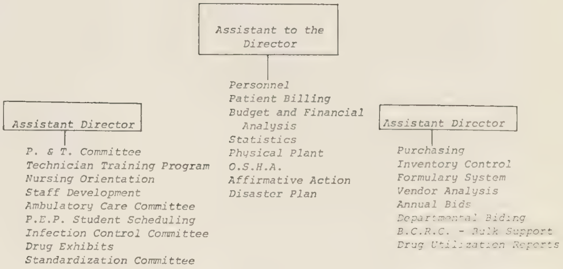
† Vincent de Paul Burkhart, M.S., is Director of Pharmacy Services, University of Maryland Hospital, Baltimore, Maryland, and Assistant Clinical Professor, University of Maryland School of Pharmacy.

Research, to date, for the Department, has been in concert with the Residency Program. Studies have been conducted involving quality assurance, the pharmacist's role in patient consultation and education, computer capabilities for pharmacy and department administration using management by objective techniques. A current study involves assessment of the pharmacists's role in acute care medicine.

The unit dose system at the University of Maryland Hospital has as its basis not only the provision of individual doses, but more importantly, the monitoring of each patient's drug therapy. This monitoring is accomplished by using a Patient Therapy Monitoring Record (PTMR). The PTMR is utilized for all inpatients and lists demographic and clinical information along with medication dispensing data. This information is received via a direct copy of the physician's order (Fig. 4). The PTMR also serves as the source for patient billing.

Unit dose was implemented some five years ago concurrently with the first satellite pharmacy. During the pilot program period with unit dose, it became apparent that many advantages existed over the department's previous multi-dose drug distribution system. The multi-dose system had provided a five day supply of oral medications and a two day supply of injectables. In converting the patient medication profile data from one system to the other, it was found that information used in the multi-dose system was about 48 hours behind the nursing station medication data. This, obviously, posed many problems, especially with discontinued drug orders and screening for drug incompatabilities. In addition to over-

(Figure 1)

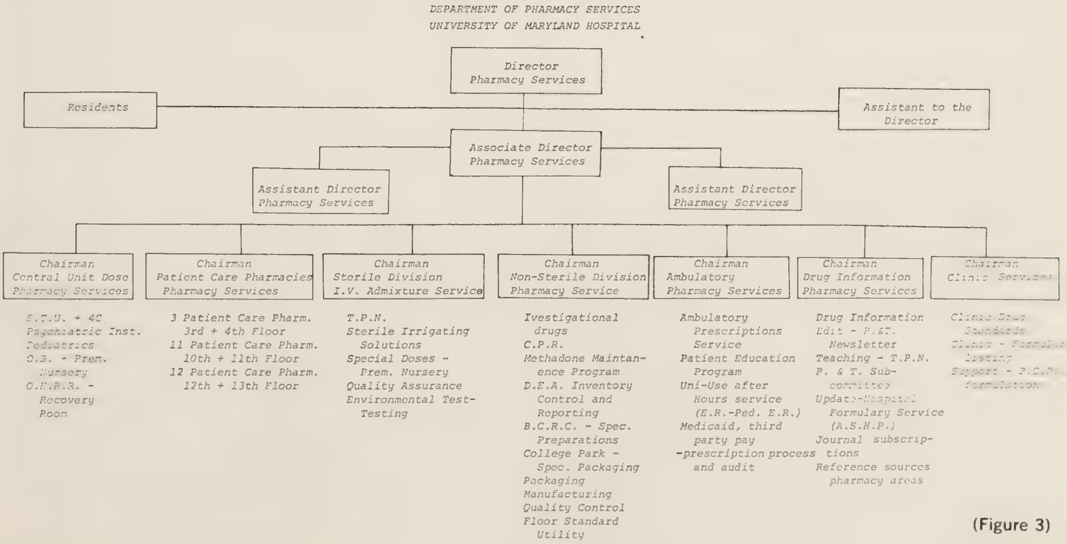


Assistant to the Director
- Personnel
- Patient Billing
- Budget and Financial Analysis
- Statistics
- Physical Plant
- O.S.H.A.
- Affirmative Action
- Disaster Plan

Assistant Director
- P. & T. Committee
- Technician Training Program
- Nursing Orientation
- Staff Development
- Ambulatory Care Committee
- P.E.P. Student Scheduling
- Infection Control Committee
- Drug Exhibits
- Standardization Committee

Assistant Director
- Purchasing
- Inventory Control
- Formulary System
- Vendor Analysis
- Annual Bids
- Departmental Biding
- B.C.R.C. - Bulk Support
- Drug Utilization Reports

(Figure 2)



DEPARTMENT OF PHARMACY SERVICES
UNIVERSITY OF MARYLAND HOSPITAL

Director Pharmacy Services
- Residents
- Assistant to the Director
- Associate Director Pharmacy Services
  - Assistant Director Pharmacy Services
  - Assistant Director Pharmacy Services

Chairman Central Unit Dose Pharmacy Services
- S.T.U. + 4C
- Psychiatric Inst.
- Pediatrics
- O.B. + Prem. Nursery
- O.H.R.R. - Recovery Room

Chairman Patient Care Pharmacies Pharmacy Services
- 3 Patient Care Pharm. 3rd + 4th Floor
- 11 Patient Care Pharm. 10th + 11th Floor
- 12 Patient Care Pharm. 12th + 13th Floor

Chairman Sterile Division I.V. Admixture Service
- T.P.N.
- Sterile Irrigating Solutions
- Special Doses - Prem. Nursery
- Quality Assurance
- Environmental Test-Testing

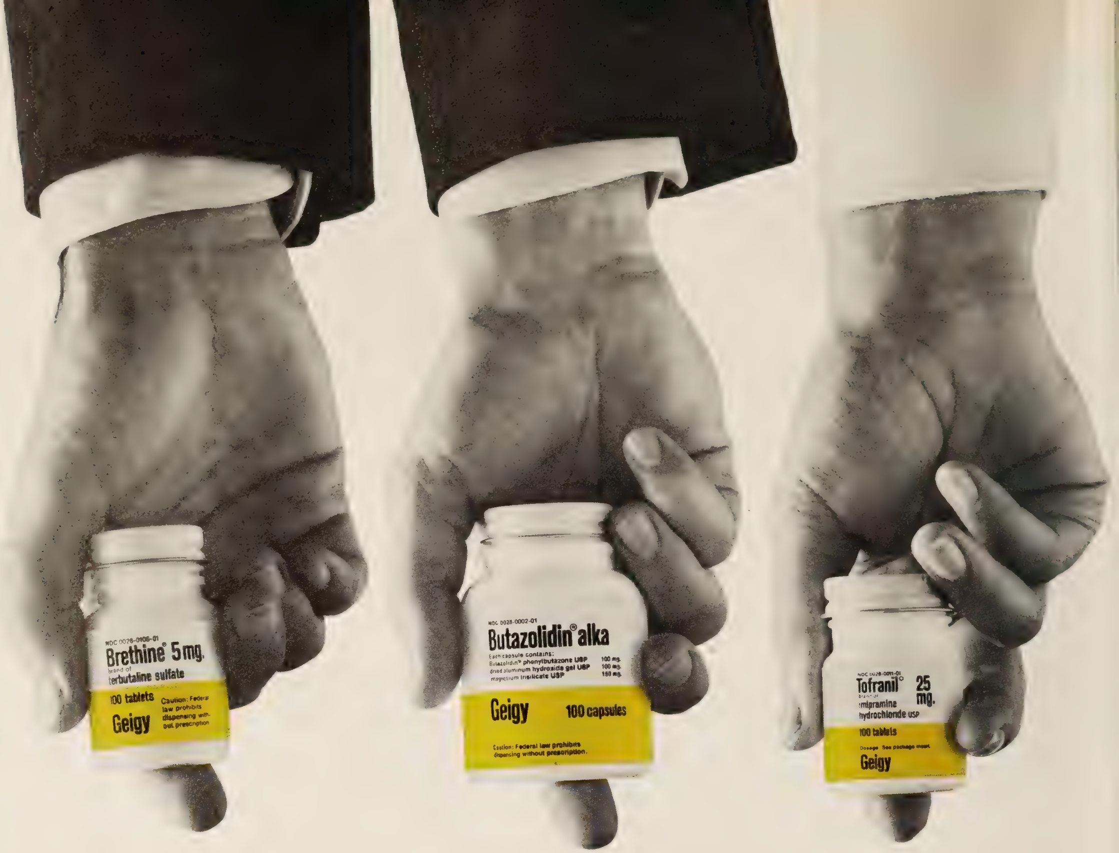
Chairman Non-Sterile Division Pharmacy Service
- Ivestigational drugs
- C.P.R.
- Methadone Maintanence Program
- D.E.A. Inventory Control and Reporting
- B.C.R.C. - Spec. Preparations
- College Park - Spec. Packaging
- Packaging
- Manufacturing
- Quality Control
- Floor Standard Utility

Chairman Ambulatory Pharmacy Services
- Ambulatory Prescriptions Service
- Patient Education Program
- Uni-Use after Hours service (E.R.-Ped. E.R.)
- Medicaid, third party pay -prescription process and audit

Chairman Drug Information Pharmacy Services
- Drug Information
- Edit - P.&T. Newsletter
- Teaching - T.P.N.
- P. & T. Subcommittee
- Update-Hospital Formulary Service (A.S.H.P.)
- Journal subscriptions
- Reference sources pharmacy areas

Chairman Clinic Services
- Clinic Drug Standards
- Clinic - Formulary listing
- Support - B.C.R.C. formulation

(Figure 3)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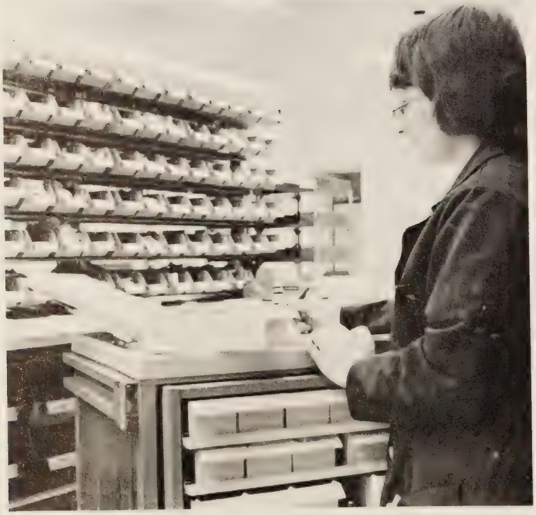
coming these problems, the unit dose system reduced the drug costs to the patient since the patient was only charged for medications administered. As the decentralized unit dose program developed, the Department realized the need to provide supportive assistance to the pharmacists relative to the many technical aspects (Fig. 5). Supportive personnel are utilized to allow the pharmacist to react to patient-related activities. Training for these supportive personnel is provided by an on-going eight week training program.

The professional role of the pharmacist, relative to the unit dose system, is the interpretation of the physician's order, monitoring the patient's medication profile, verifying the patient's daily medications being dispensed, and providing accurate information for proper administration.

There are many similarities in the centralized and decentralized systems. Both provide individual doses utilizing medication carts which are exchanged every twenty four hours. Interim orders and doses are processed and delivered to the patient areas using couriers. Pharmacists in both systems are responsible for specific patient populations. Currently, there is a satellite on every other floor servicing six floors of the Hospital and specific patient population assignments are dictated logistically. Pharmacists, in both systems, periodically review all pharmacy profile data with nursing administration data and the patients chart (Fig. 6).

(Figure 4)



(Figure 5)

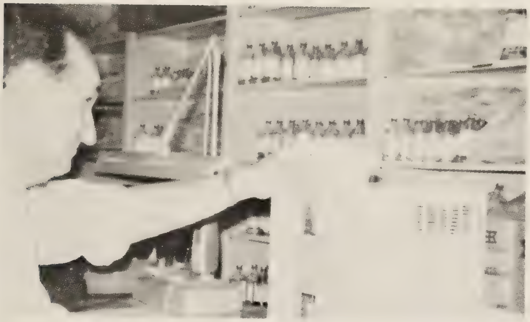
The basic difference between the two systems is that the decentralized pharmacies have the pharmacist as a readily available resource in the patient care area. This advantage has proven to solve many of the drug related problems in the Hospital. In all areas staff rotation is held at a minimum to allow for consistent follow-up in both the monitoring of the patient and interdisciplinary communication. Both the centralized and decentralized pharmacy areas are supported by a sterile and non-sterile service.

The Sterile Support, consisting of the Intravenous Admixture Laboratory and a Syringe Filling Laboratory, is presently preparing approximately 600 parenteral doses per day. These doses include all scheduled I.V. medications, sterile irrigating solutions, total parenteral nutrition formulations, syringes and special doses prepared for the premature nursery. All I.V. admixtures are prepared using aseptic technique under laminar air flow units (Fig. 7). Environmental testing is periodically performed as part of the area's quality assurance program to guarantee the integrity of these preparations. Orders for supportive intravenous doses are received in the Intravenous Admixture Service via a communicative device (Telautograph^R) from the satellite areas (Fig. 8); on the other hand, the C.U.D. area is adjacent to this service and has direct access to the I.V. Laboratory.

The Non-Sterile Support Service provides unit dose packaging and manufacturing to all areas of the pharmacy, handles investigational drugs, services a campus Methadone Maintenance Program, prepares special doses for the Baltimore Cancer Research Center, and is responsible for all D.E.A. controlled substances. This service prepares all unit doses not commercially available and special pediatric liquid doses in oral syringes (Ped-Pods^R) (Fig. 9). Both the sterile and non-sterile support services are intended to "free-up" the pharmacist directly assigned to a patient population, so that maxi-

(Figure 6)

(Figure 7)



(Figure 8)

mum patient related activities can be achieved. Additionally, these areas provide information about product formulation and serve as a basis for the Department's quality assurance program.

The Ambulatory Pharmacy is located on the first floor of the Hospital, adjacent to the clinic elevators. Currently the Ambulatory Pharmacy is preparing approximately 400 prescriptions per day. Pharmacists counsel patients on the proper use of medications and emphasize compliance as part of the area's patient education program. Outpatients are counseled in individual booths and are provided with printed material to take home as a follow-up in the Department's patient education program (Fig. 10).

The Drug Information Service, located in the eleventh floor P.C.P., responds to questions concerning drug therapy. Most of the questions arise from physicians, pharmacists and nurses with occasional requests from outside institutions and community pharmacies. The Drug Information Service is responsible for participation in interdisciplinary educational programs, editing the Pharmacy and Therapeutics Committee Newsletter and updating the Hospital Formulary Service.

In addition to providing direct pharmacy services from the Ambulatory Pharmacy, the Department is responsible for drug control throughout the 66 specialty clinics of the Hospital. This drug control is overseen by a Clinic Coordinator who also acts as a liaison regarding other pharmacy matters, such as Medicaid, Rules and Regulations, departmental policies, etc., with the clinic areas.

(Figure 9)

(Figure 10)

The challenge to the hospital pharmacist today is to find ways to provide these comprehensive pharmacy services at a reasonable cost. These costs are affected by many external sources which demand quality of care and set rates. Institutions and departments must meet standards set by the Joint Commission for the Accreditation of Hospitals (J.C.A.H.), must answer to State Licensure Inspectors, must justify costs for existing State Cost Review Commissions or will probably be required to react, in the future, to President Carter's proposed Hospital Cost Containment Act. Hospital pharmacists are constantly faced with an ever increasing demand for services which are both cost effective and progressive. Unit dose drug distribution systems, Central I.V. Admixture Services and Formulary Systems are some of the well documented services that provide quality pharmaceutical patient care on a cost contained basis.

Articles regarding the pharmacy services at institutional settings within Maryland are welcomed and encouraged.

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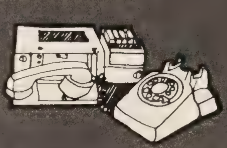

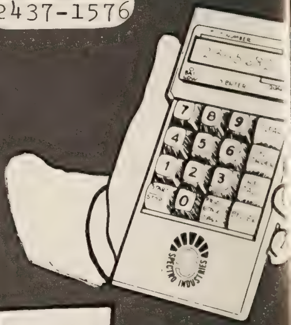

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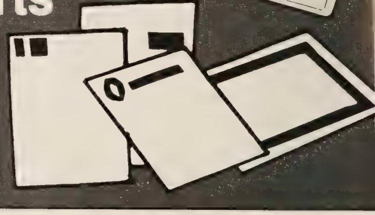

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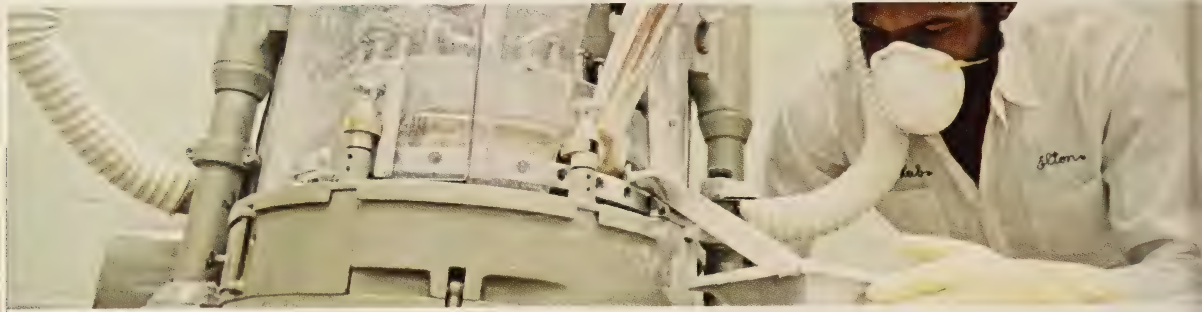

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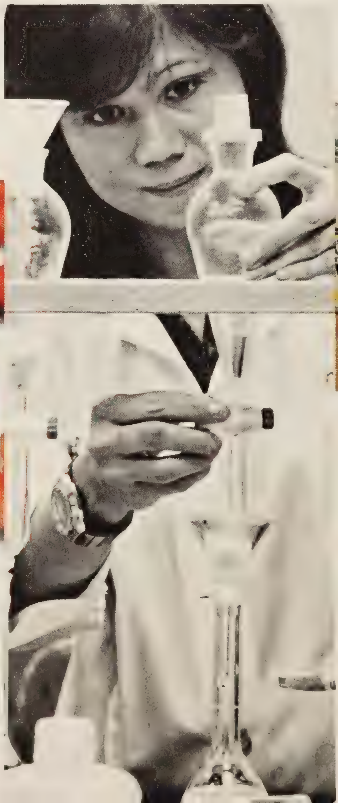

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* Data on file, Lederle Laboratories

063-7

(Continued from page 7)

Bill Brown (l.) of Geigy Pharmaceuticals makes a presentation to Mrs. Mel Rubin.

Some well-wishers at the reception for Executive Director Banta.

The House of Delegates in session at the 95th Annual Convention in Ocean City.

Just a sampling of the good times at the crab feast at Berlin, held during the Annual Convention.

— Photos courtesy of
Paramount Photo Service

Joseph Dorsch Recipient of Bowl of Hygeia Award

Joseph U. Dorsch was honored at the 95th Annual Convention of the Maryland Pharmaceutical Association as its 1977 recipient of the "Bowl of Hygeia" Award. The award is presented each year to a Maryland pharmacist for outstanding community service.

Mr. Dorsch is a graduate of the University of Maryland School of Pharmacy. He is a partner in Voshell's Pharmacy, with two sites in West Baltimore.

He is a member of the American Pharmaceutical Association, Maryland Pharmaceutical Association, member and past president of Baltimore Metropolitan Pharmaceutical Association, and Fellow of the American College of Apothecaries.

In his community, Mr. Dorsch is member and Past President of the West Baltimore Businessmen's Association, St. Joseph's Community Association, St. Agnes Neighborhood Association and the Knights of Columbus.

Joseph Dorsch is married and the father of three children, all of whom have graduated or are working toward various degrees in pharmacy.

Robert Varipapa Joins ASHP Staff

Robert J. Varipapa, Pharm.D., a 1977 graduate of the University of Maryland School of Pharmacy, has been named Assistant Editor on the *American Hospital Formulary Service* staff.

Mr. Varipapa had previously worked at the Maryland Poison Information Center and had served as editor for *Pharm-Alert*, a newsletter published by the Student Committee on Drug Abuse Education at the School of Pharmacy.

calendar MP

Sept. 20 (Tues.) — Alumni Association Meeting

Sept. 27 (Tues.) — BMPA Meeting — Pharmacy Law revision

Sept. 29 (Thurs) — State-MPhA Seminar on Laws and Inspections — Sacred Heart Hospital — Cumberland

Oct. 2-6 — NARD Convention, Washington, D.C.

Oct. 10-18 — MPhA Trip to Rome — limited seats — reservation deadline approaching

Oct. 27 (Thurs) — MPhA Fall Regional & House of Delegates Meeting

Nov. 19 (Tues) — MPhA Simon Solomon Pharmacy Economics Seminar

Gantrisin® sulfisoxazole/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staph. aureus, P. mirabilis, P. vulgaris).* **IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections.** Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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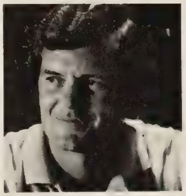
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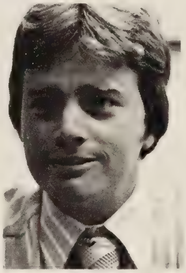
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Optional deluxe hotel accommodations at the Meridien Martinique Hotel are available. The price for this deluxe hotel package $70.00 Per Person Also included are a free half-day sailing cruise and free use of sports facilities such as tennis courts, pedal boats, sunfish and snorkelling equipment. Please check on reservation coupon if you desire this option.

Special Dining Option

A special meal option which includes 5 American Breakfasts and 4 dinners at your hotel.
To sign up for this option, check the appropriate box on the reservation coupon. $75.00 per person.

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Exciting optional tours are available. Visit quaint fishing villages, take a fun-filled Catamaran sail, stroll through lush tropical forests and banana plantations or hop over to the Grenadine Islands or the Island of Dominica. Complete details will be sent when you register for your vacation.

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*plus 15% tax and service (based on double occupancy) single supplement $90.00

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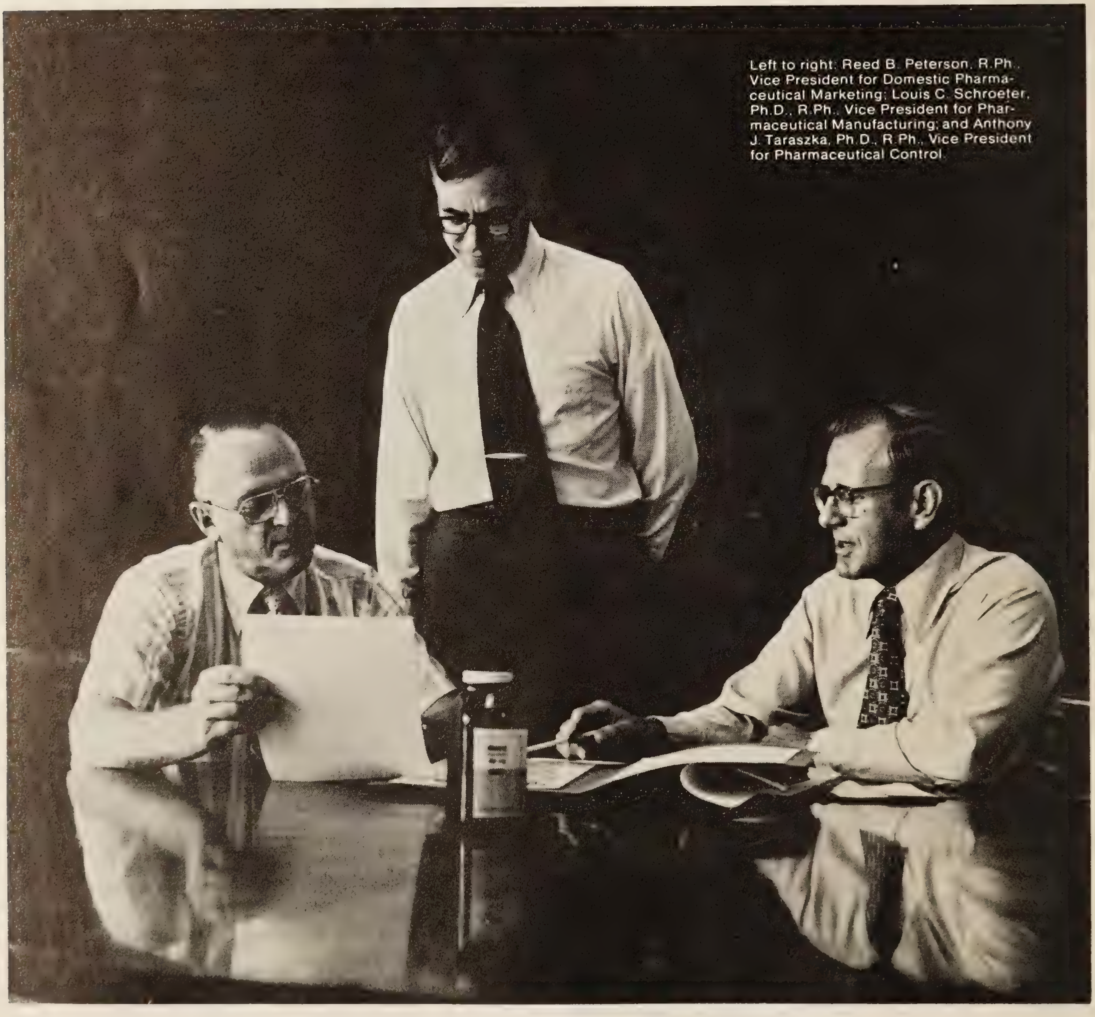

Left to right: Reed B. Peterson, R.Ph., Vice President for Domestic Pharmaceutical Marketing; Louis C. Schroeter, Ph.D., R.Ph., Vice President for Pharmaceutical Manufacturing; and Anthony J. Taraszka, Ph.D., R.Ph., Vice President for Pharmaceutical Control.

THE MARYLAND PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

OCTOBER, 1977
VOL. 53
NO. 10

Coping with State Inspections

C.E. Programs from the School of Pharmacy

Meet Maryland's New Pharmacists

**Simon Solomon Seminar
and Fall Regional Meeting
THURSDAY, OCTOBER 27, 1977**

THE MARYLAND PHARMACIST

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OCTOBER 1977 VOL. 53 NO. 10

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The Maryland Pharmacist is published monthly by the Maryland Pharmaceutical Association, 650 West Lombard Street, Baltimore, Maryland 21201. Annual Subscription — United States and foreign, $10 a year; single copies, $1.00. Members of the Maryland Pharmaceutical Association receive *The Maryland Pharmacist* each month as part of their annual membership dues. Entered as second class matter December 10, 1925, at the Post Office at Baltimore, Maryland, under the Act of March 8, 1879.

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A unique new pharmacy public relations program, developed by Eli Lilly and Company, now available through your state pharmaceutical association

Your state association has available, on loan, a series of four thirty-second television announcements that inform the public about the professional services you provide to help them understand and use medicines most effectively. Each one opens with a potential problem—patient compliance, drug interactions, adverse effects, OTC drugs—areas of great concern in public health that will hold special appeal for public service broadcasting time. Contact your state association office for more details.

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BRETHINE®
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Tablets 5 mg., Tablets 2.5 mg. *Before prescribing or administering, please consult complete product information, a summary of which follows:*

Tablets contain 5 mg. (equivalent to 4.1 mg. of free base) or 2.5 mg. (equivalent to 2.05 mg. of free base) of Brethine, brand of terbutaline sulfate.

Indications: As a bronchodilator for bronchial asthma and for reversible bronchospasm which may occur in association with bronchitis and emphysema.

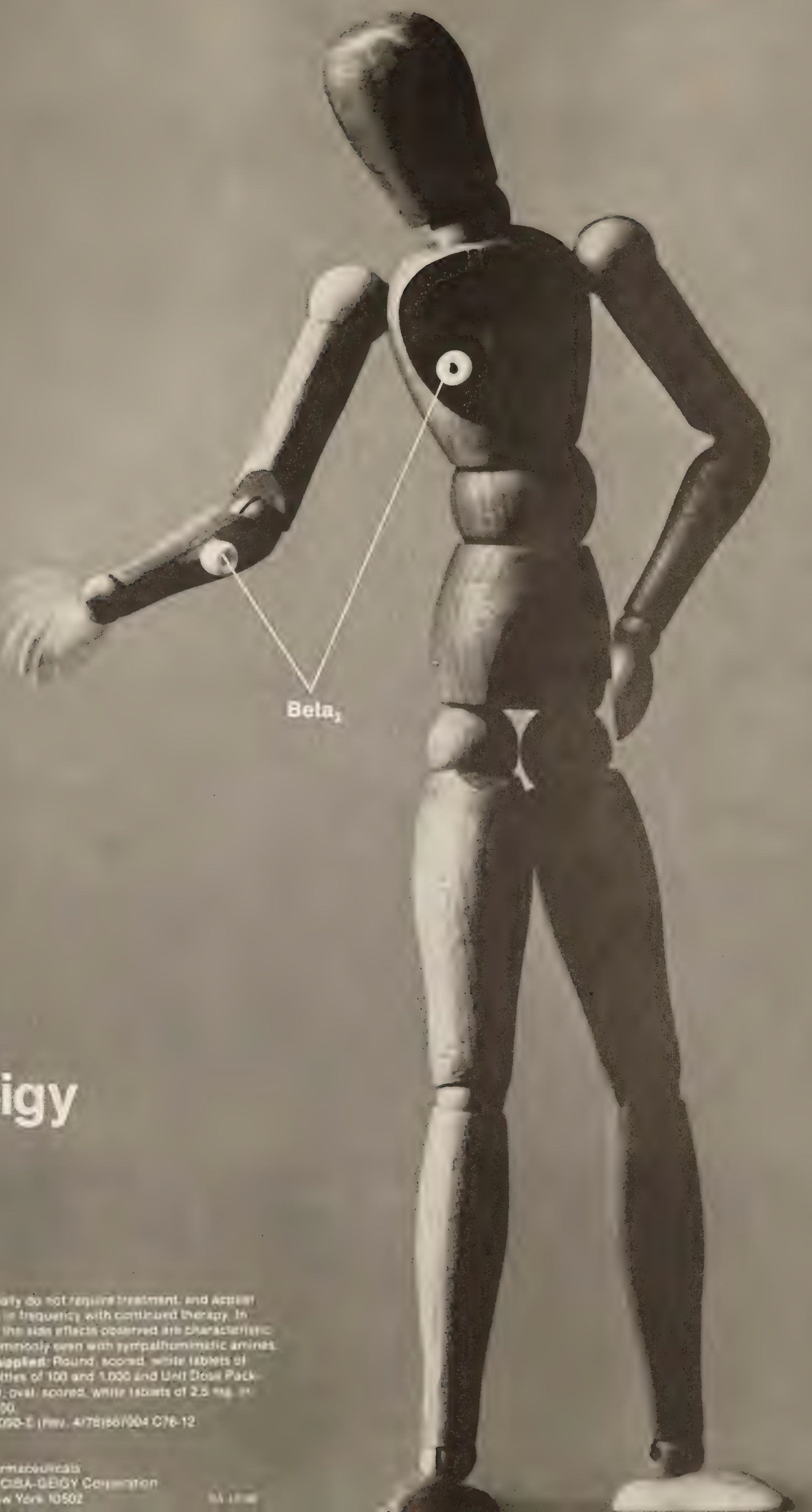
Contraindications: Known hypersensitivity to sympathomimetic amines.

Warnings: *Usage in Pregnancy:* The safety of the use of Brethine, brand of terbutaline sulfate, in human pregnancy has not been established. The use of the drug in pregnancy, lactation, or women of childbearing potential requires that the expected therapeutic benefit of the drug be weighed against its possible hazards to the mother or child.

Usage in Pediatrics: Brethine, brand of terbutaline sulfate, tablets are not presently recommended for children below the age of twelve years due to insufficient clinical data in this pediatric group.

Precautions: Brethine, brand of terbutaline sulfate, should be used with caution in patients with diabetes, hypertension, and hyperthyroidism. As with other sympathomimetic bronchodilator agents, Brethine, brand of terbutaline sulfate, should be administered cautiously to cardiac patients, especia those with associated arrhythmias. Although the co comitant use of Brethine, brand of terbutaline sulfa with other sympathomimetic agents is not recommended, the use of an aerosol bronchodilator of th adrenergic stimulant type for the relief of an acute bronchospasm is not precluded in patients receivin chronic oral Brethine, brand of terbutaline sulfate, therapy.

Adverse Reactions: Commonly observed side effects include nervousness and tremor. Other reported reactions include headache, increased hear rate, palpitations, drowsiness, nausea, vomiting, an sweating. These reactions are generally transient in



Geigy

nature, usually do not require treatment, and appear to diminish in frequency with continued therapy. In general, all the side effects observed are characteristic of those commonly seen with sympathomimetic amines.

How Supplied: Round, scored, white tablets of 5 mg. in bottles of 100 and 1,000 and Unit Dose Packages of 100; oval, scored, white tablets of 2.5 mg. in bottles of 100.

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A special meal option which includes 5 American Breakfasts and 4 dinners at your hotel.
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*plus 15% tax and service (based on double occupancy) single supplement $90.00

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President's Message

In our profession we have owners, employers, educators, etc. . . . We are very sorely lacking in the areas of legislative activity and public relations.

Any pharmacist with political aspirations should seek election to the State legislature or other office. Our position must be voiced at the general assembly and every other regulatory body affecting our future. We must also seek opportunities to speak before civic fraternal, religious, and service organizations. Now is the time to stand up and be counted.

If you are interested in public office, contact the officers of Pharmpac for assistance and guidance. If you would like to be a speaker or if you need a speaker to address a group, contact the Association office.

The committees of M.Ph.A. are now busy with the tasks of formulating policies and plans. If you would like to be an active member of your profession, volunteer as a worker. Attend the seminars and regional meetings.

Stand up and voice your opinion.

At no time in our history has this organization been without problems and challenges. Today is no exception. We face an increasing barrage of public scrutiny into prices and practices. We also have the challenge of professionalism. Stand up to the challenge and be a better pharmacist. Participate in continuing education programs to meet the demands of today's higher standards of practice. Present a good image to the public in all your activities, at work and socially. Only then can we show the Supreme Court and the citizenry it represents, where we stand as a profession.

Richard Parker

Coping with State Inspections

compiled by

Melvin N. Rubin

Drug Control Inspectors work with a "Pharmacy Inspection Report" (reprinted on page 11), to determine whether or not you are in compliance with State and Federal regulations.

The following numbered items are explanations of the various inspection points taken from the report. If you understand and compile the following information, you should have no difficulty during an inspection.

It is recommended that you detach this page from the Journal and post it in the pharmacy. Fill in the blank spaces with the location of the required information to serve as a guide to relief pharmacists in case an inspection is held while the owner/manager is off duty. Be sure to refer to this list from time to time to ensure you are always ready for an inspection.

The numbers of the following explanations correspond with the Check List (Pharmacy Inspection Report). Numbers which have been skipped means that that item is self-explanatory. Read the two lists together and copy in information where appropriate.

1. Location of *Maryland* CDS Registration ______________________________

2. Location of *Federal* CDS Registration ______________________________

3. "No transfer" sticker must be on container of CDS prescriptions. If you elect to have the statement pre-printed on labels instead of affixing an auxiliary label, information must be in at least 6 point type (Note: "no transfer" information should *not* be on *non* CDS prescriptions). This would require your using two sets of pre-printed labels, one to control dangerous substance prescriptions and another for all other prescriptions.

4. Refills must be recorded on back of prescription (proposed regulations would allow option of recording on approved profile systems). Pharmacist initials are *required* on CDS items, *suggested* on all other refills.

5. Location of Schedule V Book ______________________________

(Must be kept for sale of Schedule V non-prescription items such as Codeine Cough syrups and must include date sold, name/address of patient, pharmacist initials, name/quantity of drug. (Baltimore City and County require prescriptions for Codeine containing cough syrups and prescriptions do not have to be recorded in this book).

6. Phoned authorization for additional refill on CDS item must be treated as a *new* prescription with new number. You cannot just note additional refill on back of prescription.

7. Location of old prescription files ______________________________

(Must be retained for five (5) year minimum)

8. There are three (3) methods of maintaining prescription files:
   a. Schedule II on one file, others on one file, with III, IV, V identified by Red C.
   b. Schedule II, III, IV, V on one file, identifying II, IV, V with Red C, prescriptions for non-scheduled drugs on separate file.
   c. Three separate files (non-scheduled, II and III, IV, V files. No Red C required.

9. Red C must be in lower right hand corner, 1 inch high on prescriptions as described in 8 above. Use stamp, not marker or crayon.

10. Location of CDS Inventory

Must have date, time, and be signed by the person responsible for taking it and be maintained at the location appearing on the registration form at least two (2) years.

11. Location of Schedule III, IV, V invoices

12. Must be dated when received, must be kept separate from non-scheduled drug invoices or be readily retrievable. Must be retained for two (2) years.

13. Location of Federal order forms (old "narcotic forms")

Pharmacy copy must have quantity and date item received filled in on each line. Invoices for items must be easily retrievable or kept with Federal forms, and both must be retained for two (2) years.

17. Maximum of 34 days supply or 100 doses (whichever is less) allowed for amphetamine of methamphetamine. This does *not* apply to other Schedule II items such as Ritalin, Nembutal, Preludin.

18. Schedule II may be disbursed throughout inventory. If not, they must be kept under lock and key.

19. Physician or other practitioner may not write a prescription for purpose of general dispensing to patients. (Cannot state "for office use")

20. Only pharmacists, pharmacy students, or specifically authorized personnel may participate in handling or dispensing of CDS items. If not a licensed pharmacist, individual must be under the immediate supervision of a licensed pharmacist.

21. Only pharmcists, pharmacy students, and specifically authorized persons allowed in prescription area.

22. Outdated item on shelf is considered as offered for sale. This includes Over the Counter products and cosmetics such as hair dyes.

23. Labeling violations such as incomplete information on products packaged in the pharmacy constitute misbranding (i.e. Over the Counter product packaged without full directions for use and warnings; pre-packs which do not have expiration date and control number).

24. Pertinent date such as control number and expiration date, directions for use on over the counter must not be covered.

25. Location of Pharmacy Permit

26. Location of Pharmacist State Board Certificate

27. Location of Pharmacist current renewal

28. Location of latest USP and supplements

29. Location of latest NF

30. (Utensil list is being updated and will be printed in a later copy of MARYLAND PHARMACIST.)

33. Label must be attached securely to bottles or vial, not slipped inside vial.

34. Law requires label to contain expiration date and directions for storage if known, name of drug unless physician specifies otherwise, etc.

35. Prescription presented more than 120 days after issue must be verified with prescribing practitioner.

36. Poison register must be maintained if poisons are sold.

37. Syringe, needle register must have name/address of purchaser, date of sale, item, signature of pharmacist. (can only be sold by pharmacist).

39. Refrigerator must be below 46°. Freezer from −4° to 14°.

41. Nitroglycerin products, except Nitroglyn, must be in unopened, full bottles. Ipecac can be sold in maximum of 1 oz. size bottle over the counter. Full directions must be affixed to the container.

42. Pharmacist must be on duty at all times when pharmacy is open.

43. Safety closure required unless patient or physician requests otherwise. Written authorization for use of non-safety is *suggested.* Air/light resistant containers are required in all cases.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
ENVIRONMENTAL HEALTH ADMINISTRATION
DIVISION OF DRUG CONTROL

PHARMACY INSPECTION REPORT

NOTICE: Failure to comply with any of the applicable provisions set forth in Art. 27, sec. .276 through sec. 302 of the Annotated Code of Maryland; and Art. 43, sec. 187 through Sec. 197 of the Annotated Code; and Art. 43, sec. 249 through sec. 289 of the Annotated Code may subject you to civil proceedings by the Department of Health and Mental Hygiene, and/or possible prosecution by the States Attorney's office, may lead to suspension or revocation of your Controlled Dangerous Substances Registration; and referral to the Maryland Board of Pharmacy for its consideration and action.

Pharmacy Name ____________________ Address ____________________

Inspection Date ____________________ Arrival Time ____________________ Departure Time ____________________

Division of Drug Control Requirements	Yes	No
1. Md. CDS Registration Current		
2. Federal CDS Registration Current		
3. Federal "No Transfer" Sticker/Label with no less than 6 pt. type		
4. Rx Date Refills Recorded as Required		
5. Data Relative to Schedule V Maintained		
6. CDS Expired Refills Reduced to New Rx when Dr. wishes patient to continue use		
7. Rx Files Maintained for 5 Years		
8. CDS Rx Filing as Required — Two or Three File System		
9. Red "C" Used on Prescriptions When Required		
10. CDS Inventory Properly Recorded with Month, Year, and Time		
11. Schedule III, IV and V Invoices Dated When Received		
12. CDS Invoices Readily Retrievable		
13. Third Copy of Federal Order Form Properly filled in		
14. Patient Address on CDS Prescriptions		
15. Physician Address on CDS Prescriptions		
16. Physician DEA No. on CDS Prescriptions		
17. Amphetamin Regs. in Compliance		
18. Are Schedule II Drugs Dispersed, If Not All Kept under Lock and Key		
19. CDS Prescriptions Filled for Practitioners Own Use		
20. Authorized Personnel Only Fill CDS Prescriptions		
21. Security and Control Adequate to Keep Unauthorized Personnel out of Rx Dept.		
22. Outdated Products Offered for Sale		
23. Misbranded Products Offered for Sale		
24. Pertinent Data on Pkg. Labels Not Obstructed by Price Sticker or Crayon		
25. Other Observation — See Observation Sheet		

Board of Pharmacy Requirements	Yes	No
25. Current pharmacy permit posted conspicuously		
26. Pharmacist State Board Certificate posted conspicuously		
27. Pharmacist current certificate of renewal available		
28. Latest decennial USP and supplements on hand		
29. Latest edition of NF and supplements on hand		
30. All required pharmaceutical utensils on hand		
31. Running water available		
32. Pharmacy kept clean and orderly		
33. Labels properly affixed to patient containers		
34. Required data on patient's label, i.e., expiration date, etc.		
35. Prescription presented more than 120 days after issuance		
36. Poison Register Maintained		
37. Paraphernalia register maintained — syringes, needles, etc.		
38. Refrigeration or protection of drugs from light, exposure, etc.		
39. Refrigerator/freezer temperature		
40. Prescription price poster in position for customer to read		
41. Nitroglycerin storage and Ipecac dispensing		
42. Pharmacy under (personal or immediate) supervision of reg. pharmacist		
43. Safety closures used as required		
44. Sanitary precautions taken in handling medications		

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BMPA Goes to the Fair

The Baltimore Metropolitan Pharmaceutical Association participated in the first annual city Health Fair held in the Lexington Market in Baltimore. Mickey Friedman *(left)* distributes some information to a consumer at the fair while Marvin Oed *(right)* looks on.

Mickey Friedman *(left)* and Charlie Spigelmire *(right)* coordinated the BMPA effort at the Fair including the transportation to the Fair of the MPhA display front shown behind them.

— Photos courtesy of
Paramount Photo Service

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C.E. Programs from the School of Pharmacy

by
HENRY G. SEIDMAN
Director, Continuing Education
University of Maryland
School of Pharmacy

The Continuing Education Division of the School of Pharmacy University of Maryland is pleased to announce that effective July 1, 1977 this School was approved by the American Council on Pharmaceutical Education as a provider of Continuing pharmaceutical education.

The ACPE is the National Agency for approval of Continuing Education providers and accreditation of professional degree programs in pharmacy.

CORRESPONDENCE
SERIES #176 and #177
CONTINUING PROFESSIONAL EDUCATION

The Continuing Education Division of the University of Maryland School of Pharmacy is again pleased to announce the offering of two Continuing Education *Correspondence Series* of current interest to pharmacists. Each series consists of six (6) courses. Each course is especially prepared for Extension study.

An answer sheet and self addressed envelope is provided for each course. The answer sheet should be returned to the School of Pharmacy for grading upon completion of each course. The courses should be completed within the time period of the academic year or within a reasonable time thereafter.

CEU Credit

For those desiring Continuing Education Credit, the School of Pharmacy (through the Division of Continuing Education) will award 1.2 Continuing Education Units (CEU), or twelve (12) contact hours upon successful completion of the six courses. One must score a minimum of 70% per test in order to be awarded 1.2 CEU.

The CEU is a means of recognizing and recording the efforts of individuals who enroll and satisfactorily complete this non-degree program. For those desiring CEU credit, records will be established at the School of Pharmacy. A certificate suitable for framing will be awarded by the school upon successful completion of each six course series.

You may register for both courses, if you wish.

Cost

The six courses of each series are available for only $30.00. There are a limited quantity of course #176 which has been revised and improved. This course was offered last year and enjoyed immediate approval. *Series #176 Courses are:*

1. Diabetes Mellitus — The Disease and Its Therapy
2. Vitamins
3. Patient Records — Patient Consultation
4. Managing Analgesics
5. Bioavailability
6. Arthritis — Rheumatoid and Degenerative Joint Disease

New for 1977-1978

Series #177 is just being released and will be issued during the year from September 1977 to May 1978. The six courses offered in Series #177 are:

1. The Pharmacist and Contact Lenses
2. Asthma
3. The Treatment of Epilepsy
4. The Use of Cough and Cold Preparations
5. The Treatment of Glaucoma
6. Acne — Disease and Treatment

The University of Maryland School of Pharmacy's correspondence courses are:

- A convenient, informative program that helps you improve professional competence at your own pace, at your own home or at work, and at a cost you can afford.
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PLEASE NOTE: The two correspondence courses are just part of the Continuing Education Program of the School of Pharmacy. The remainder of the program is now being finalized; a brochure will be distributed in the next couple of weeks. Included in the offerings, which will be detailed in the forthcoming brochure, are:

1. A SEMINAR — "COMMUNICATIONS IN PHARMACY"
   To be held on October 27, 1977 — the Simon Solomon Seminar — in co-sponsorship with the Maryland Pharmaceutical Association.
2. A SEMINAR — "MINOR TRANQUILIZERS — THEIR ROLE IN TODAY'S WORLD"
   Fee $7.50. Supported by the ROCHE Company — November 9, 1977 — 7:00-10:00 p.m.
3. DENTAL-PHARMACY PROGRAM — Fall Program — November-January
   To be presented by Dr. Richard M. Oksas
   Will be held in four areas of the state: Baltimore, College Park, Cumberland, Easton.
   Will include a review of important Dental-Pharmacy Products. Will discuss selected disease states. Will examine the interaction of Pharmacist and Dentist.

(Continued on page 17)

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*__Warning:__ May be habit forming.

†Data available from an independent research service show TYLENOL with Codeine tablets to be the most frequently prescribed narcotic-containing analgesic combination.

Contraindications: Hypersensitivity to acetaminophen or codeine
Warnings: *Drug dependence:* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to other oral narcotic medications. Subject to the Federal Controlled Substances Act
Usage in ambulatory patients: Caution patients that codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery
Interaction with other CNS depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) with this drug may exhibit additive CNS depression. When such a combination is contemplated, reduce the dose of one or both agents
Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards
Precautions: *Head injury and increased intracranial pressure:* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries
Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions
Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture
Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting; more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus
Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.
For information on symptoms and treatment of overdosage, see full prescribing information

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C.E. Programs

(Continued from page 15)

4. DRUG PRODUCT SELECTION — Spring Program — from February-May
   Also to be held in four areas of the state. Seminar or roundtable — (Hospital Pharmacy, Community Pharmacy, Chain Pharmacy) deals with:
   (a) Update of Law
   (b) Responsibilities of Pharmacists
   (c) How to Communicate with Patient and Physician
   (d) Criteria and Mechanism for Assuring Product Quality
5. FULL DAY SEMINAR — "PHARMACY AND THE GERIATRIC PATIENT"
   9:00 a.m.-3:30 p.m.
   Fee: $20.00 — includes luncheon, coffee break and materials.
   Dr. Peter P. Lamy, Professor of Pharmacy and Director of Institutional Pharmacy Programs at the University of Maryland School of Pharmacy, will direct this program. Dr. Lamy has devoted extensive time to this subject and has given many lectures in the area. He is a recognized authority on geriatric pharmacy.
6. JOURNAL CLUBS
   A pilot program of Journal Clubs will be introduced this year in two selected areas to determine the feasibility of offering small group continuing education learning to our practitioners. The Journal Club combines both social and educational activity and allows for interpersonal reinforcement. It appears to be an ideal way to develop a learning experience where distance, time and other factors might otherwise make attendance at a program a problem. Details will follow.

Please be on the look-out for a brochure from us with dates, times, and places completed for the entire program. Save the brochure for ready reference throughout the year. The Continuing Education Division is attempting to meet the varying needs of today's busy pharmacists by providing several forms of C.E. presentations.

For additional information please phone (301) 528-7589/7118 or write:

Henry G. Seidman
Director, Continuing Education
University of Maryland
School of Pharmacy
636 West Lombard Street
Baltimore, Maryland 21201

The University of Maryland School of Pharmacy is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education.

Clinical Facts For Your Information

- EATING food just before oral administration of either ampicillin or amoxicillin reduces serum levels and urinary excretion of the drugs. The reduction in drug absorption following a meal may be of greater clinical significance for ampicillin than for amoxicillin, according to an article in APhA's Jnl. of Pharmaceutical Sceinces. *DRUG TOPICS, MAY 1, 1977. P. 93.*
- TETRACYCLINES are not effective against viruses, which cause 90% of upper and 50% of lower respiratory tract infections in children, nor are they the drugs of choice for the four bacteria that cause pneumonia in children. *JAMA, MAY 9, 1977. P. 2101.*

A White House proposal to ban the use of barbituates outside hospitals has been prompted by findings that "more persons die from barbituates than all other drugs put together." DRUG TOPICS, MAY 1, 1977. P. 29.

- BARBITUATES may influence vitamin D metabolism in the elderly. Following a clinical impression that low serum calcium and elevated alkaline phosphatase values were unduly frequent in elderly patients on barbituates, a retrospective study was based on a biochemical survey of 403 people over 65 in general practice. *INPHARMA, MAY 14, 1977. P. 15.*
- ERYTHROMYCIN appears to be the drug of choice for acute bacterial infections of the larynx and trachea which are not life-threatening, for single-drug treatment of sinusitis, and for otitis media pending the results of bacteriology, except in severely ill patients at risk of meningeal spread. *INPHARMA, MAY 7, 1977. P. 3.*
- AGGRAVATION of diabetic hyperglycemia by chlordiazepoxide. Review of the literature shows that virtually all psychoactive drugs affect diabetes; most tranquilizers aggravate diabetic hyperglycemia, while most antidepressants ameliorate it. The effect described in this communication is of clinical importance because of the widespread use of the benzodiazepine tranquilizers. *JAMA, MAY 2, 1977. P. 1960.*
- NEISSERIA GONORRHOEAE resistant to high levels of spectinomycin were isolated from specimens obtained from a patient with urethritis. The bacterial resistance to spectinomycin is probably due to ribosomal changes that are a result of a chromosomal mutation. If spectinomycin fails to cure gonorrhea, spectinomycin resistance should be considered. *JAMA, MAY 30, 1977. P. 2405.*
- EYEDROPS containing a mixture of guanethidine and adrenaline appear to have a promising future in the treatment of glaucoma. Adrenaline reduces introocular pressure in 2 ways. It acts via the alpha receptors to increase the outflow of fluid and via the beta receptors to decrease aqueous secretion. *MED TRIB, MAY 11, 1977. P. 2.*

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Smoking Behavior and Attitudes of Physicians, Dentists, Nurses, and Pharmacists, 1975

The proportion of physicians, dentists, and pharmacists who smoke cigarettes has decreased markedly, according to a 1975 national survey* of the smoking behavior and attitudes of professional health personnel. Results of the survey, which were compared with earlier surveys conducted between 1967 and 1969 (Tables 1 and 2), also indicate that smoking among nurses is at about the same level as it was in 1969 (39% in 1975 vs. 37% in 1969). By contrast, the proportion of physicians who smoke dropped from 30% in 1967 to 21% in 1975; dentists from 34% in 1967 to 23% in 1975; and pharmacists from 35% in 1968 to 28% in 1975. Although a greater proportion of nurses are smoking compared to the other professional groups surveyed, nurses smoke fewer cigarettes per day than physicians, dentists, and pharmacists who smoke (Table 2).

TABLE 1. Smoking behavior of 4 health professional groups, 1967 and 1975.

Smoking Behavior	% Physicians 1967	% Physicians 1975	% Dentists 1967	% Dentists 1975	% Pharmacists 1968	% Pharmacists 1975	% Nurses 1969	% Nurses 1975	% U.S. Adult Population (1975) Male	% U.S. Adult Population (1975) Female
Female										
Current Smoker	30	21	34	23	35	28	37	39	39	29
Former Smoker	36	37	34	41	30	34	22	22	29	14
Never Smoked	35	42	32	36	35	38	41	40	32	57

TABLE 2. Smoking behavior of 4 health professional groups by number of cigarettes smoked/day, 1967 and 1975.

Number of cigarettes smoked per day by current smokers	% Physicians 1967	% Physicians 1975	% Dentists 1967	% Dentists 1975	% Pharmacists 1968	% Pharmacists 1975	% Nurses 1969	% Nurses 1975	% U.S. Adult Population (1975) Male	% U.S. Adult Population (1975) Female
1-14	31	36	33	38	22	27	45	38	23	33
15-24	30	34	39	35	46	40	44	46	40	44
25 or more	39	29	28	27	32	32	12	16	36	23

If data are looked at by age group, nurses under 40 years of age also show a decrease in smoking from 1969 (39%) to 1975 (34%). In those nurses 40 and over, there is an increase (35% in 1969 to 42% in 1975). This increase is the result of a cohort change and does not mean that many nurses took up smoking during this 6-year period. Nurses born between 1928 and 1935 — large numbers of whom began smoking before the evidence on the harmful effects were well-known — were under 40 in the first survey and over 40 in the more recent one. Among physicians, dentists, and pharmacists, both age groups (under 40 as well as 40 and over) showed decreases in the percentage of current smokers.

Health professionals, with the exception, again, of nurses, smoke less than the adult population as a whole, 34% of whom smoke (MMWR 26[19], 1977). Additionally, more smokers in the male-dominated** professions smoke less than 15 cigarettes per day than in the general male population (Table 2). Similarly, nurses (in the sample, 98% were female) smoke fewer cigarettes per day than adult women in the population as a whole; however, the difference was not as great. In all 4 professional groups, smokers used lower tar and nicotine cigarettes (15 mg or less) than the general population (Table 3).

The 4 groups were also queried concerning their attitudes about smoking and their responsibility in reducing the related death and disability. People in the 4 professions generally and increasingly see cigarette smoking as a cause of heart disease and oral cancer and as either a major cause or contributing cause of lung cancer, chronic bronchitis, and pulmonary emphysema. Most of the professionals reported that they believe it is their role to set a good example by not smoking (Table 4), that it is their responsibility to convince people to stop smoking and that they should be more active in speaking to lay groups about cigarette smoking. Health professionals were also found to be increasingly optimistic about their ability to effect change in their patients' cigarette smoking behavior.

Reported by the National Clearinghouse for Smoking and Health, Bur. of Health Education, CDC.

TABLE 3. Smoking behavior of 4 health professional groups by mg. tar in cigarettes, 1975.

Mg. of tar in cigarette smoked[1]	% of Current Smokers: Physicians 1975	Dentists 1975	Pharmacists 1975	Nurses 1975	Adult Population (1975) Male	Adult Population (1975) Female
20 and over	19	11	20	9	26	13
16-19	61	65	62	68	61	70
15 and less	19	23	18	23	13	17

[1] Information on tar content received only from those answering mail questionnaire

TABLE 4. Health professionals' responsibility as seen by health professionals, 1975.

Health Professionals' Responsibilities	% Who Strongly Agree or Somewhat Agree: Physicians	Dentists	Pharmacists	Nurses
Should set a good example by not smoking[1]	91	88	73	87
Should convince people to stop smoking	74	61	51	77
Should be more active than they have been in speaking to lay groups about cigarette smoking.[1]	82	68	68	74

[1] Information received only from those answering mail questionnaire

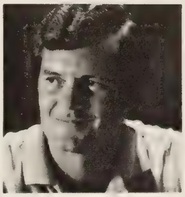
---

**This sample showed that 93% of physicians, 99% of dentists, and 90% of pharmacists are male.

*Based on questionnaires (mail and telephone) to approximately 20,000 health professionals — 5,000 in each group. Names were supplied by the American Medical Association, American Nurses Association, Inc., American Dental Association, and the American Pharmaceutical Association.

"Facing" Up to Our Responsibilities

RAY HECKMAN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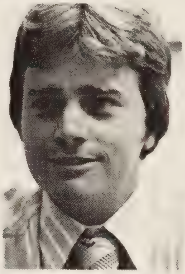
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Alarm-Related Response Procedures And Supplementary Information

by Thad L. Weber, Security Consultant, SK&F Laboratories

In the preceding issues we have discussed the necessity for the effective placement of intruder detection devices and a remote monitoring station that operates 24 hours, seven days a week.

The prompt and effective response by police and/or alarm company guards is equally important since today's criminal will keep looting until someone capable of stopping the attack arrives. To assure effective prevention of loss, I suggest the following:

1. Give the police and/or alarm company accurate instructions concerning your address, the perimeter of the premises, possible escape routes, location of lighting switches, and telephone numbers where someone can be reached who can admit the police or guards to the premises.
2. When keys to the premises are furnished to the alarm company, test them periodically for mechanical operation, and furnish new keys any time a lock cylinder is changed or added.
3. Check that police and alarm company records reflect current daily business hours so that police will know if an employee is likely to be on duty when alarm signals are received.

   Note. This is particularly important where police-connected alarm systems include both burglary and holdup alarm sensors, since police station monitoring techniques do not permit them to distinguish one alarm condition from another.
4. Provide signatures, photographs and descriptions of pharmacy employees responsible for opening, closing or supervising the business to the police or alarm company guards for proper identification in emergencies.
5. Make the alarm contractor who installs the sensors responsible for promptly determining the cause of all false alarms and for immediately repairing the equipment or eliminating the condition which caused the unnecessary alarm. You should cooperate if building structure or operation conditions require repairs or changes on your part.

Burglar Alarm Systems—Supplemental Information

1. *All* sensors and control units installed at the premises should be operated from a reliable power source equipped with a standby power supply that will sustain the system without interruption during power outages for periods of at least five hours during sustained power failures.

Thad L. Weber

2. Alarm shunt control locks, required where police station supervision is involved, should be a time-delay type installed inside the premises, rather than on the outside of the premises' entrance door.
3. Prior to the installation of a burglar alarm system, you should analyze crime insurance requirements and/or incentive discounts which may be available to reduce crime insurance premiums.
4. More than one alarm sensing circuit may be supervised on a single central station direct wire system, e.g., the safe alarm, perimeter, motion detection and holdup signal devices may all be on a single monitoring position. The same applies to circuits covering multiple floors in the same building.
5. Select alarm contractors on the basis of their experience, insurance company and police department recognition, and their reputation for integrity and service in the community. I suggest you ask each prospective contractor for a list of his major customers, then call those people and obtain their comments.
6. Most burglar alarm contractors lease and retain title to their systems after making a nominal charge for installation labor and materials. If you have a short-term lease, this is probably the best arrangement. However, if you own your property or carry a long-term lease (five or more years), you may find it advantageous to obtain outright purchase quotations for comparison.
7. Alarm system contracts deserve your careful consideration and review by your attorney prior to execution to ascertain that the limitation of the alarm contractor's liability, the length of the agreement, price escalators, etc. are clearly understood.
8. Anyone familiar with the education, training, skill and experience required to prepare prescriptions can easily understand that burglar alarm systems are no do-it-yourself matter. However, careful thought should be given to price variations between competing alarm contractors. Make certain that both proposals are based on exactly the same terms, conditions and extent of alarm coverage.

A Look at Union Memorial Hospital Pharmacy

by

NORMAND PELISSIER

The Union Memorial Hospital Pharmacy Department services a 408-bed, private, non-profit, general hospital in Baltimore. The Pharmacy provides year-round 24-hour service. The Staff at present consists of 27 full-time equivalent positions. This includes a director and assistant director, three pharmacy supervisors, a clinical pharmacist, seven staff pharmacists, two pharmacy IV technicians, eleven pharmacy assistants (technicians) and two students.

Pharmacy services include a unit-dose 24-hour exchange system, an IV additive service, filling of outpatient prescriptions and publication of a monthly pharmacy newsletter. The activities of the clinical pharmacist include attendance at Rounds with physicians, lecturing, nursing-pharmacy liaison, providing drug information, conducting drug utilization studies, new product evaluation and patient monitoring in selected clinics.

The Pharmacy processes 45,000 inpatient orders per month, each order generally representing a 24-hour supply of drugs. This includes approximately 4,500 IV additive solutions per month. In addition, approximately 2,000 outpatient prescriptions are filled monthly. All inpatient charges are processed on a 24-hour basis, seven days a week. Technicians enter a 7-digit drug code number and the quantity issued on a computer print-out listing all patients by room number. After an initial supply of a drug is issued, the code number is preprinted on the next day's print-out. On a typical day, 1,500 drug orders representing approximately 4,500 individual doses are charged out by the coding technicians in this manner.

Future plans for the Pharmacy call for computerization of patient profiles and of the inventory and ordering system. Expansion of clinical pharmacy services is also planned.

Computer controlled pneumatic tube system is used to send "stat" drugs to nursing units.

Pharmacy technician Ronald Buckson places unit-dose liquid in patient bin. All bins are double-checked by pharmacist before leaving the pharmacy.

Staff pharmacist Stephen Gerardi prepares hyperalimentation solution in one of laminar flow hoods located in IV room.

Pharmacist Gerardi uses IBM Memory typewriter which provides duplicate labels automatically.

Central unit-dose dispensing area.

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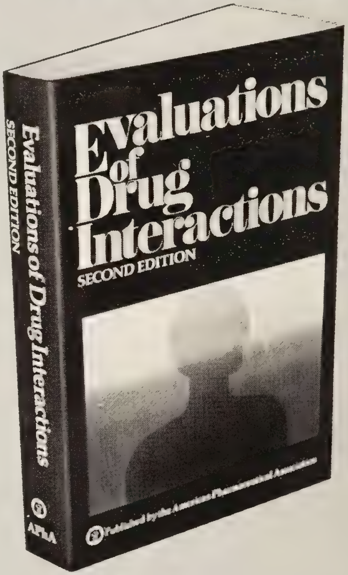
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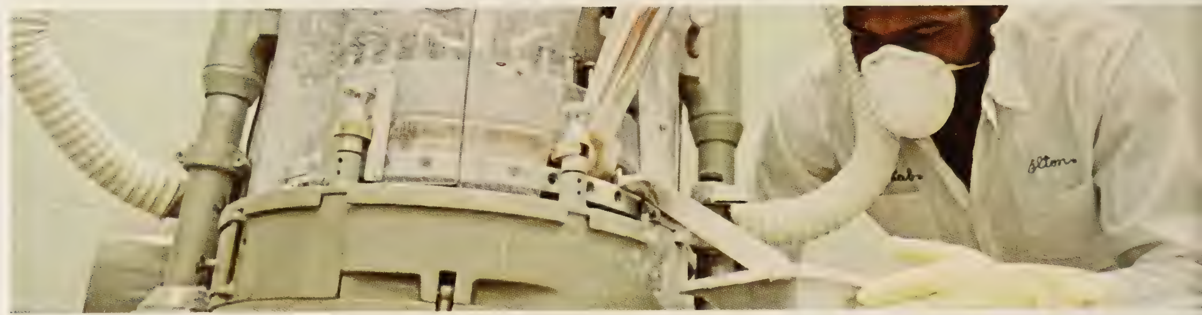

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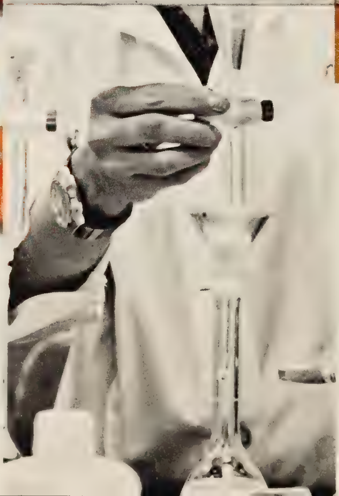

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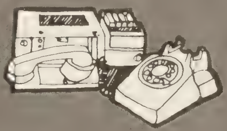

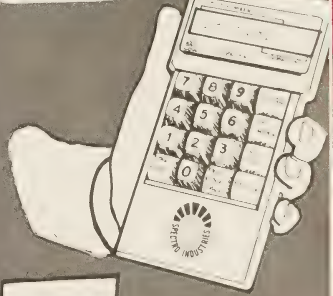

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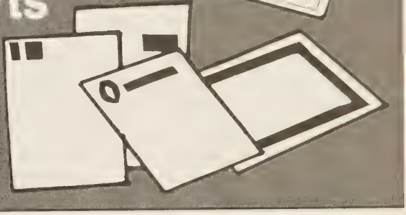

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Meet Maryland's New Pharmacists

The following persons have been granted registration by the Maryland Board of Pharmacy as a result of passing the examination conducted June 8, 9, and 10.

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Christopher B. Akinbinu
Leslie Alteri
Carla J. Beckman
Kenneth A. Bialek
Margaret D. Black
Franklin W. Blatt
James P. Blonoheim
Howard Blumenfield
Mariann Bowles
Cathy A. Brilhart
Michelle K. Broll
Anthony J. Brooks
Margaret C. Brophy
Ronald E. Brown
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Kristine W. Ellinger
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Adeline I. Enechi
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Geraldine L. Epley
Ruth E. Farrell
Julius A. Fashesin
Benjamin O. Fawehinmi
Harry B. Finke, Jr.
Alan C. Ford
Timothy C. Funk
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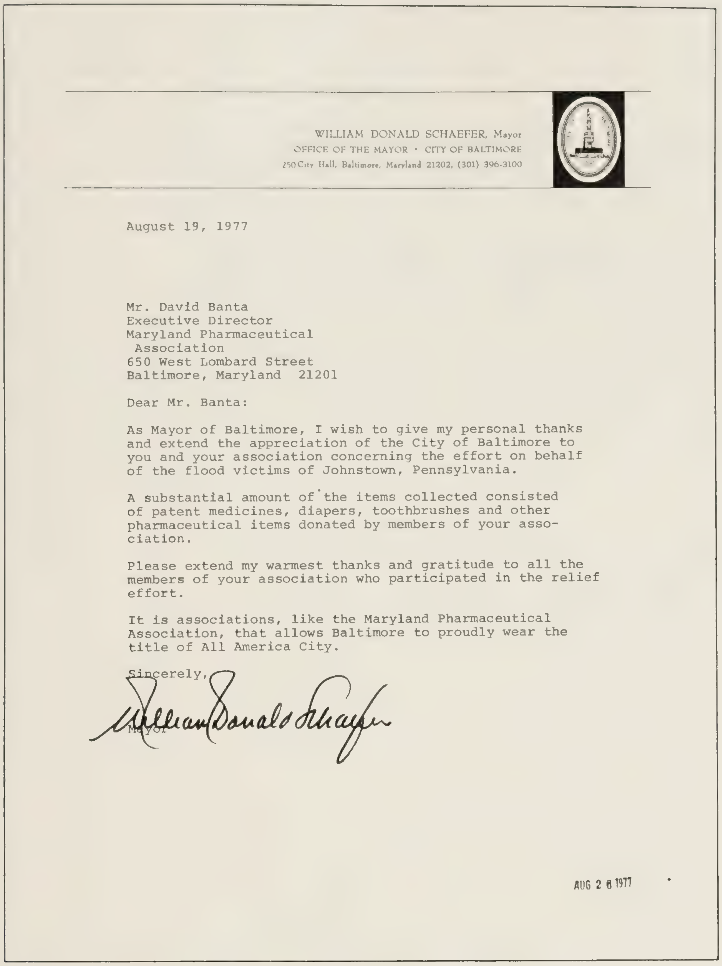
Linda A. Shapiro
Douglas W. Sherwood
Daniel M. Simos
Judith W. Smith
Abiodun Somide
Sue R. Sonnenberg
Paul E. Starr
Minette M. Sterling
Janice D. Stolarek
Brian J. Swartz
Lawrence C. Taylor
Michael Tiburzi, Jr.
Rebecca L. Tominack
Irene M. Georgiou
John M. Hale
Steve Hamilton, Jr.
Rebecca Hayford
Steven J. Hess
Charles D. Imwold
Mark T. James
Wanda T. Janicki
Eric Johnson
William F. Kearney
Ronald A. Keech
James M. Kellner
Bonita A. Kolish
John P. LaFranchise
Marian V. Lawrence
John E. Loftus
Michael P. Long
Raymond C. Love
Denise A. Lupo
Meer H. Majeed
Donna B. Mallard
Karen J. Mason
Luisa F. Massari
Stuart R. McCamant
Deborah L. Mintzer
Alicia M. Morrow
Doan-Trang T. Nguyen
Godson O. Okonrende
John M. Oliver
Emmanuel A. Olubodun
Gabriel B. Olukunke
Kampanart Panasethaned
Daniel S. Pastorek
Michael S. Patton
Donna K. Peacock
Katherine Pozoulatis
Joseph T. Rackson
Robert J. Varipapa
Joann Vudragovich
Judith D. Wagner
David Watson, Jr.
Mark S. Wienecke
Wanda K. Wolfe
Brenda K. Yad
John W. Young
Mary A. Young
Janet Thaxter
Ruth Thompson

The following persons passed the theoretical examination, but registration was withheld until they meet the legal requirements for practical pharmacy experience and have passed an examination in practical pharmacy.

Mary M. Corr
Brenda J. Herndon
John M. Jacobs
Fay O. Lim
Richard W. Maynert
Carlton L. Mills
Deborah L. Penrod
Richard V. Piacentini
Richard S. Sabatelli
Barbara A. Saliunas
Vincent Santavenere
Nancy J. Scienzo
Raymond Scienzo
Cynthia A. Statton

Letter to the Editor



WILLIAM DONALD SCHAEFER, Mayor
OFFICE OF THE MAYOR · CITY OF BALTIMORE
250 City Hall, Baltimore, Maryland 21202, (301) 396-3100

August 19, 1977

Mr. David Banta
Executive Director
Maryland Pharmaceutical
Association
650 West Lombard Street
Baltimore, Maryland 21201

Dear Mr. Banta:

As Mayor of Baltimore, I wish to give my personal thanks and extend the appreciation of the City of Baltimore to you and your association concerning the effort on behalf of the flood victims of Johnstown, Pennsylvania.

A substantial amount of the items collected consisted of patent medicines, diapers, toothbrushes and other pharmaceutical items donated by members of your association.

Please extend my warmest thanks and gratitude to all the members of your association who participated in the relief effort.

It is associations, like the Maryland Pharmaceutical Association, that allows Baltimore to proudly wear the title of All America City.

Sincerely,

William Donald Schaefer
Mayor

AUG 26 1977

Classified Advertisements

Future issues of the MARYLAND PHARMACIST will carry a new Classified Advertisement Section as a free benefit to Association members. Any member who is seeking employment, has a job to offer, or an item for sale should send that information to: The Editor, MARYLAND PHARMACIST, 650 West Lombard St., Baltimore, Md. 21201. Blind Ads will also be accepted.

Weiner is President Alumni Association

Mr. William Weiner was recently installed as President of the Alumni Association of the University of Maryland's School of Pharmacy.

Weiner, a native of Baltimore, finished second in his graduating class in 1944 when he received a B.S. in Pharmacy from the University of Maryland.

An employee with the Read's Incorporated chain of drug stores since 1946, Weiner was recently named Vice President of Calvert Drug Co.

A.Z.O. NEWS

Kappa Chapter of the AZO Pharmaceutical Fraternity will hold its Fall Regional Meeting on November 4th, 5th and 6th at the Lord Baltimore Hotel. For information please contact Dennis Klein at 484-3919. Dr. Stanley Klatsky was the featured speaker at the September 11 meeting of the AZO Auxiliary held at the Holiday Inn in Pikesville. Dr. Klatsky spoke on "Cosmetic Surgery: A Whim or a Necessity".

APHA Meeting Plans

The 1977 American Public Health Association (APHA) Annual Meeting will be held October 30-November 3 in Washington, D.C., with the theme "Toward a National Health Policy." Each year during the APHA Annual Meeting, the American Association of Colleges of Pharmacy and the American Pharmaceutical Association cosponsor the Pharmacy/Public Health Session.

The title of this year's Pharmacy/Public Health Session is: "Competence in Pharmacy: What's Happening and Where Should We Go From Here?" The session will be held on Sunday, October 30, 1977 from 2:00 p.m. until 5:00 p.m. in the Senate Room of the Mayflower Hotel. Pharmacy educators and practitioners from Washington, D.C., Maryland and Virginia will attend the session and participate in the audience discussion which follows the panel presentations.

THE DAILY PHARMACIST

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U.S. Pharmocopeial Temperature Bulletin

Due to the energy crisis, thermostats in pharmacies might be set below the range of "controlled room temperature," defined by the United States Pharmacopeia and the National Formulary as 59-86°F. Exposure of drug products to these lower temperatures may result in undesirable physical changes that affect strength or quality. The following suggestions are offered by the USP:

1. Keep from freezing. Watch temperatures in storerooms and warehouses that may be separate from the pharmacy. This is especially important with lotions, emulsions, magmas, gels, and suspensions, because they may not resuspend even upon reaching warmer temperatures.

2. Look for precipitates. This may occur with solutions such as injectibles, elixirs, ophthalmic solutions, etc. Mannitol Injection, Formaldehyde Solution, and Diatrizoate Meglumine and Diatrizoate Sodium Injection, are examples of this. Patients should be advised that solutions should *not* be utilized while precipitation or crystallization is present, as variable dosages may result. Precipitation or crystallization is most likely to occur where the solute is close to the point of saturation. USP advises that in such instances the product should be warmed to about 75°F with warm water and shaken to dissolve the solute before dispensing. Since precipitation of some drugs may be a sign of chemical deterioration, or that the drug should not be used (e.g., Aminophylline Injection), pharmacists will want to assure themselves in such cases that the precipitate is probably due to the temperature decrease rather than to a degradation product. A list of the solubilities of official drugs is contained on page 775 of the Pharmacopeia and page 1045 of the National Formulary. Individual statements in the monograph may be helpful; also see Stability Considerations in Dispensing Practice, USP p. 707.

3. Look for separation in liquids. Solutions containing oils, such as mouthwashes, elixirs, or syrups, may appear cloudy; a layer of oils may separate on top. These preparations should also be warmed to about 75°F and if necessary, shaken in an attempt to dissolve or resuspend.

4. Check for hardness. The cold may produce hardening of ointments and suppositories and increases in the viscosities of ordinarily viscous solutions.

5. Read the labeling. Special temperature requirements for that particular formulation or that particular container may be designated by the manufacturer.

Robert E. Snyder Selected for Purdum Award

Robert E. Snyder, director of pharmacy services at Maryland General Hospital, was the recipient of the W. Arthur Purdum Award at the Maryland Society of Hospital Pharmacists' Annual Seminar held this past June. The annual award is the highest honor for a Maryland hospital pharmacist and is presented in recognition for significant contributions and influential leadership in the practice of pharmacy.

Mr. Snyder is a 1955 graduate of the University of Maryland School of Pharmacy. He joined Maryland General Hospital in 1958 as a staff pharmacist and was appointed director of pharmacy services in 1965.

In addition to holding membership in MSHP, MPhA, ASHP and APhA, Mr. Snyder is assistant professor of clinical pharmacy at the School of Pharmacy. In 1965 he was appointed by the Governor of Maryland to a five year term on the Maryland Board of Pharmacy, on which he has served as secretary-treasurer.

calendar MP

Oct. 10-18 MPhA Trip to Rome
Oct. 13 (Thurs) MSHP Meeting — Good Samaritan Hospital
Oct. 19 (Wed) Baltimore Veteran Druggists Assn.
Oct. 20 (Thurs) MPhA Board of Trustees Meeting
Oct. 27 (Thurs) MPhA Regional Meeting and Solomon Seminar
Oct. 28 (Fri) MSHP Special Fall Seminar
Oct. 19 (Wed) U of M School of Medicine C.E. Program "Drugs & The Elderly"
Nov. 4-6 AZO Fraternity Regional Convention, Lord Baltimore Hotel
Nov. 20 (Sun) Alumni Association Open-Pit Bull & Oyster Roast
Jan. 7-15 MPhA Winter trip to Martinique
Feb. 12 (Sun) BMPA Annual Installation Dinner-Dance — Blue Crest

Victor Morgenroth Honored by University of Maryland

Victor H. Morgenroth, Jr., a community pharmacist and graduate of the University of Maryland School of Pharmacy who has distinguished the school and the profession by his many activities in pharmacy, was awarded an honorary Doctor of Science degree at the commencement exercises of the University of Maryland at Baltimore on June 3. A resident of Ellicott City, he is a co-partner of Voshell's Pharmacy Inc., which operates two professional pharmaceutical centers on Wilkens Avenue in Baltimore. Above, University of Maryland School of Pharmacy Dean William J. Kinnard, Jr. adjusts the new hood as UMAB Chancellor Albin O. Kuhn congratulates Mr. Morgenroth.

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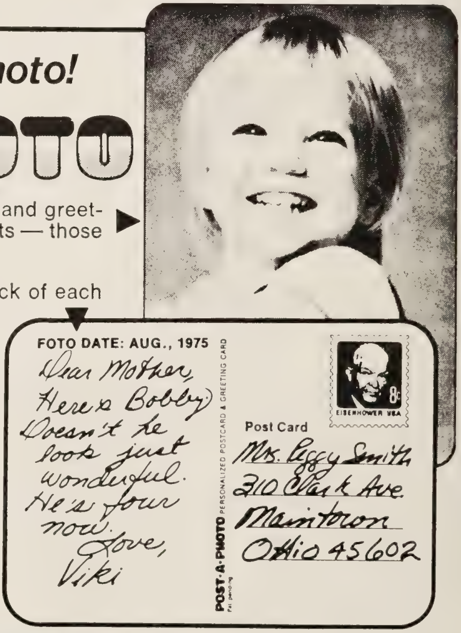

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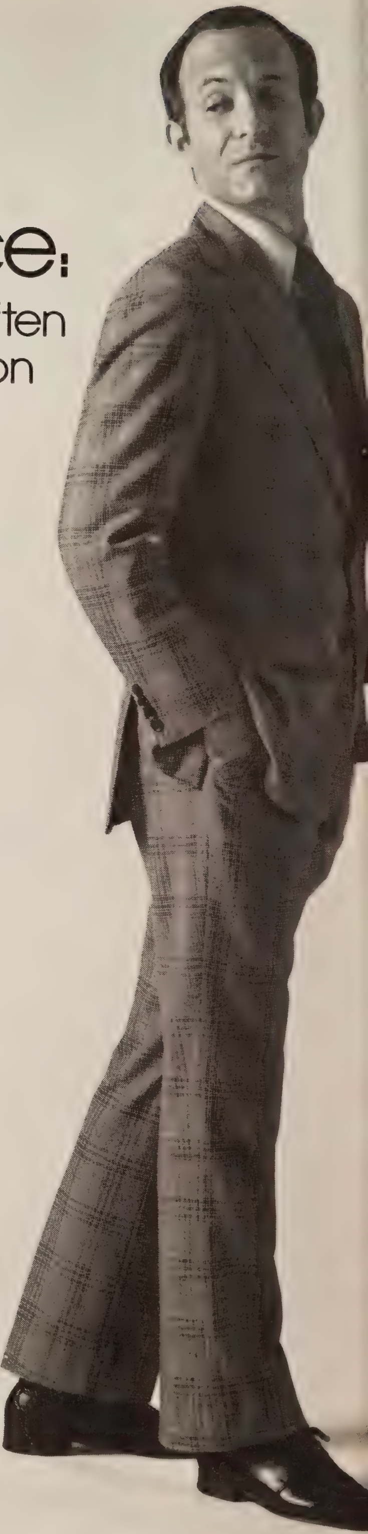

THE MARYLAND PHARMACIST

Official Journal of
The Maryland
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NOVEMBER, 1977
VOL. 53
NO. 11

Dangers of the 'Last Chance' Diet

Pharmacy and Industry — Facing the Future Together

M.Ph.A.'s Remarks to HEW on National Health Insurance

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
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*See asterisked paragraph on next page.

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ATIVAN® (LORAZEPAM) Ⓒ
prescribing information

Contraindications: Ativan is contraindicated in patients with known sensitivity to the benzodiazepines or with acute narrow-angle glaucoma.

Warnings: Ativan is not recommended for use in patients with a primary depressive disorder or psychosis. As with all patients on CNS-acting drugs, patients receiving lorazepam should be warned not to operate dangerous machinery or motor vehicles and that their tolerance for alcohol and other CNS depressants will be diminished.

Physical and Psychological Dependence: Withdrawal symptoms similar in character to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepine drugs. These symptoms include convulsions, tremor, abdominal and muscle cramps, vomiting and sweating. Addiction-prone individuals, such as drug addicts and alcoholics, should be under careful surveillance when receiving benzodiazepines because of the predisposition of such patients to habituation and dependence.

Precautions: In patients with depression accompanying anxiety, a possibility for suicide should be borne in mind.

For elderly or debilitated patients, the initial daily dosage should not exceed 2 mg in order to avoid oversedation.

Ativan dosage should be terminated gradually since abrupt withdrawal of any antianxiety agent may result in symptoms similar to those for which patients are being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions.

The usual precautions for treating patients with impaired renal or hepatic function should be observed.

*In patients where gastrointestinal or cardiovascular disorders coexist with anxiety, it should be noted that lorazepam has not been shown to be of significant benefit in treating the gastrointestinal or cardiovascular component.

Esophageal dilation occurred in rats treated with lorazepam for more than one year at 6 mg/kg/day. The no-effect dose was 1.25 mg/kg/day (approximately 6 times the maximum human therapeutic dose of 10 mg per day). The effect was reversible only when the treatment was withdrawn within two months of first observation of the phenomenon. The clinical significance of this is unknown. However, use of lorazepam for prolonged periods and in geriatric patients requires caution, and there should be frequent monitoring for symptoms of upper G.I. disease.

Safety and effectiveness of Ativan in children of less than 12 years have not been established.

Essential Laboratory Tests: Some patients on Ativan have developed leukopenia and some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended for patients on long-term therapy.

Clinically Significant Drug Interactions: The benzodiazepines including Ativan produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

Carcinogenesis and Mutagenesis: No evidence of carcinogenic potential emerged in rats during an 18-month study with Ativan. No studies regarding mutagenesis have been performed.

Pregnancy: Reproductive studies in animals were performed in mice, rats, and two strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all of these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At doses of 40 mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses.

The clinical significance of the above findings is not known. However, an increased risk of congenital malformations associated with the use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during the first trimester of pregnancy has been suggested in several studies. Because the use of these drugs is rarely a matter of urgency, the use of lorazepam during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant, they should communicate with their physician about the desirability of discontinuing the drug.

Nursing Mothers: It is not known whether oral lorazepam is excreted in human milk like the other benzodiazepine tranquilizers. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions: Adverse reactions, if they occur, are usually observed at the beginning of therapy and generally disappear on continued medication or upon decreasing the dose. In a sample of about 3,500 anxious patients, the most frequent adverse reaction to Ativan is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent adverse reactions are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, together with various gastrointestinal symptoms and autonomic manifestations. The incidence of sedation and unsteadiness increased with age.

Small decreases in blood pressure have been noted but are not clinically significant, probably being related to the relief of anxiety produced by Ativan.

Overdosage: In the management of overdosage with any drug, it should be borne in mind that multiple agents may have been taken.

Manifestations of Ativan overdosage include somnolence, confusion and coma. Induced vomiting and/or gastric lavage should be undertaken followed by general supportive care, monitoring of vital signs and close observation of the patient. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection, U.S.P. Caffeine and Sodium Benzoate Injection, U.S.P. may be used to counteract CNS depressant effects. The usefulness of dialysis has not been determined.

Dosage and Administration: Ativan is administered orally. For optimal results, dose, frequency of administration and duration of therapy should be individualized according to patient response. To facilitate this, scored 1.0 and 2.0 mg tablets are available.

The usual range is 2 to 6 mg/day given in divided doses, the largest dose being taken before bedtime, but the daily dosage may vary from 1 to 10 mg/day. For anxiety, most patients require an initial dose of 2 to 3 mg/day given b.i.d. or t.i.d.

For insomnia due to anxiety or transient situational stress, a single daily dose of 2 to 4 mg may be given, usually at bedtime.

For elderly or debilitated patients, an initial dosage of 1 to 2 mg/day in divided doses is recommended, to be adjusted as needed and tolerated.

The dosage of Ativan should be increased gradually when needed to help avoid adverse effects. When higher dosage is indicated, the evening dose should be increased before the daytime doses.

Most Common Schedules (utilizing 1-mg tablets)

	Morning	Afternoon	Evening
T.I.D.	◯	◯	◯
B.I.D.	◯		◯ ◯

How Supplied: Ativan (lorazepam) is available in scored 1.0 and 2.0 mg tablets in bottles of 100. Tablets 1.0, 2.0 mg, in Redipak® Strip Pack, Wyeth, boxes of 25.

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President's Message

Is Pharmacy Here To Stay?

Recently the Tripartite Committee prepared a draft bill entitled the "Pharmacy Practices Act" for presentation to the Maryland General Assembly for enactment into law. This proposed bill would replace the existing section of the law which governs the practice of pharmacy and remove some outdated or unworkable provisions of the current law. The draft represents the work of many individuals, but it points up the need for cooperative effort of all segments of the profession.

Ideally, the draft was to be considered by all organizations before presentation. Some groups did not actually consider the bill in a general meeting prior to the date scheduled for its introduction before the Senate Economic Affairs Committee chaired by Sen. McGuirk. Nevertheless, support for this legislation was voiced throughout the state with important input from individuals and groups made a part of the revised draft. Whether or not the bill is enacted into law, we have demonstrated the ability to work together.

There is another important area in which all segments of the profession must get it all together. National issues such as third-party prescription programs, Veterans Administration drug programs, National Health Insurance prescription coverage, federal regulations and administrative agencies harassment, etc. We must pull together on all those issues if Pharmacy is to stay a part of the health profession.

We need a voice on Capitol Hill if we are to demonstrate to the nation that we are here to stay. This could be best accomplished by having a voice in the Congress of the United States. Pharmpac works in Maryland because we are together. It must be made to work nationally.

For two years, groups of concerned pharmacists throughout the country have worked to find a way to federate state Pharmpacs or to form a National Pharmpac. Within the last few months, regional meetings of representatives from interested state groups have been held in New York, Maryland, and the District of Columbia. A nucleus of dedicated individuals decided the time to act was now and therefore a questionnaire was sent to all states asking for representatives who would be willing to serve on an advisory or steering committee and who could also provide initial funding. Federal election laws are very strict on the subject of political action committees and their formation. We are now about to embark on this task of educating members of the House of Representatives and the U.S. Senate as to the contributions of the profession of pharmacy and its need for consideration in all federal programs and agencies. We must have pharmacists on committees and boards. We must be able to speak to our legislators. We must be able to fight bad legislation and foster good legislation. If we pull together, our resources can be put to the campaigns of political aspirants who are favorable to our position on issues. This new political action committee, which will be called PULL PAC, Pharmacists United Legislative Leadership PAC, is not intended initially to act as a lobbying group, but rather to provide funds for candidates. This will leave the door open for all segments of Pharmacy to speak for their own positions through lobbying efforts of their leadership.

The voice of Pharmacy will be heard from grassroots as well as from National organizations and will show determination to be a continuing part of the health-care professions. We will not be limited to pharmacists in soliciting funds for this important group. Stay active in your profession and continue to be vocal. Survival is the name of the game, but believe me, Pharmacy is here to stay.

The DANGERS Of the 'LAST CHANCE' Diet

JOSEPH A. CORNELL, Pharm.D.*

(Reprinted with permission from the *Minnesota Pharmacist*)

ABSTRACT

The dangers of the Last Chance Diet are presented. The physiological basis of the diet is described and adverse effects and contraindications are explained. Adverse effects include kidney stones, gout, dehydration, imbalances in electrolytes, hypoglycemia, and psychological changes. Contraindications include cardiac patients, gout patients, pregnant women, liver dysfunction and kidney dysfunction. Patients should be warned not to go on this diet without the supervision of a physician.

Although the Last Chance Diet is not known to be intrinsically dangerous in the hands of competent groups of professionals, it *is* dangerous when attempted by lay persons without medical supervision. If you work in a community pharmacy in the United States, it is very likely that you have been asked at least once within the last few months whether you carry Prolinn, Pro-lite, P-86, or any one of a number of liquid protein supplements. If so, the Last Chance Diet has already touched your life.

Background

The Last Chance Diet is not just another fad diet. It is actually based upon the recently discovered physiological principle of the protein sparing modified fast (PSMF). This principle has been summarized and described by Flatt and Blackburn.[1]

The Last Chance Diet

The Last Chance Diet works in the same way. The patient stops eating altogether and takes about 300-500 calories worth of a liquid protein supplement (5-8 oz.) every 24 hours. Within about 24 hours of starting this fast, the patient starts metabolizing fat extensively and goes into a state known as ketosis. In this state, the blood becomes more acidic, and uric acid has to compete with so called "ketone bodies" to be excreted. The result is an increase in serum uric acid levels. In persons predisposed to gout, this will precipitate an attack of gout and/or kidney stone formation. Allopurinol may be given to compensate for this, but this requires a physician's evaluation. Also, the lowered pH of the blood slows conduction in the heart and may exacerbate any existing cardiac conditions.

With a relative lack of glucose available, the brain switches to metabolizing ketones for energy. It is not known whether this is the cause, but psychological disturbances are seen with this type of diet.

Protein Sparing Modified Fast

The basic problem in obesity is the large stores of fat laid down by the body at times when it has an excess of energy available. Figure 1 diagrams how this occurs. When a meal is eaten, the carbohydrate in the food consumed is broken down to sugar which is absorbed into the bloodstream. This raises the blood sugar level, which in turn stimulates the secretion of insulin. Among other things, insulin: (1) allows sugar to enter the cells throughout the body, (2) stimulates the formation of glycogen, a storage form of sugar, (3) stimulates the creation of fat from glucose, (4) inhibits the breakdown of glycogen, (5) inhibits the breakdown of amino acids and proteins, and (6) inhibits the breakdown of fat. Simply stated, insulin stimulates the storage of food energy for later use. When insulin is no longer present (i.e., when the blood sugar gets lower), the body reverses all of these storage processes and begins to use the stored energy as needed.

**Drug information pharmacist, University of Minnesota Hospitals, and assistant professor in the College of Pharmacy, University of Minnesota, Minneapolis.*

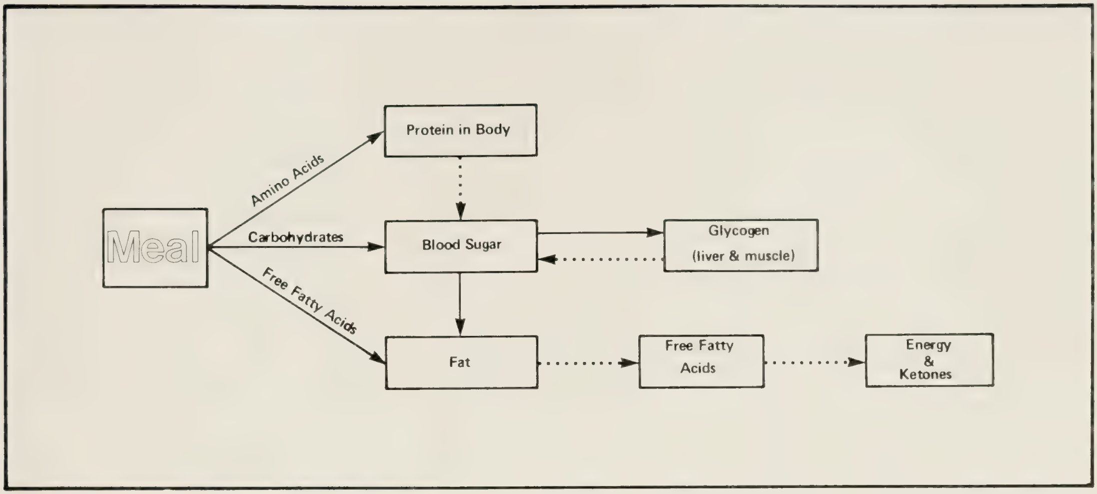

FIG. 1
Effects of insulin. Solid lines are insulin dependent steps.

It would seem straightforward then, that there is a process that will get rid of the body's fat. We would simply stop eating, the blood sugar would go low, the fat would be metabolized for energy, and soon there would be no more fat. Unfortunately, it doesn't quite work that way. The brain highly prefers glucose as a source of energy. The only glucose storage form available in the body is glycogen, but we usually have only enough for 12 to 24 hours. After that period of time, the amino acids, the building blocks of protein, must be broken down to provide sugar for the brain. As this occurs, protein is pulled out of the muscle, bone, blood, brain, and other important parts of the body. As they lose their protein, the affected cells begin to die off; once dead, many of them can never be replaced. Whenever this happens, the patient is said to be in "negative nitrogen balance," indicating that there is more nitrogen leaving the body than there is entering the body.

The traditional method of preventing negative nitrogen balance has been to give the patient carbohydrate. Carbohydrate intake results in insulin being secreted, which in theory should inhibit the breakdown of proteins. In practice what happens is that insulin is secreted, the breakdown of fat ceases, and proteins are metabolized for energy. This is very wasteful. Blackburn, *et al.*[2], have shown that patients are kept in a more positive nitrogen balance if protein, rather than carbohydrate, is given. They theorize that this is because, for all intents and purposes, amino acids do not stimulate insulin secretion. The amino acids being fed are used for the brain's glucose needs as well as to replace losses by the muscles, bone, blood, etc. Since no insulin is present, the body is then free to use fat as an energy source.

For reasons that are too lengthy to describe adequately in this paper, patients lose large amounts of sodium and potassium when they are placed on this diet. Along with these electrolytes, they lose large amounts of water, and may become dehydrated. Patients on this diet are given potassium supplements and are told to drink large amounts of fluid (usually diet pop). However, they are not given sodium because this can cause them to become waterlogged, which can also be dangerous. The amount of potassium needed must be determined by a physician by means of a serum potassium assay. Patients

(Continued on page 10)

(Continued from page 9)

must not try to go it alone by using over-the-counter potassium supplements; they could take too much, too little, or use the wrong salt of potassium. (Potassium chloride is not equivalent to potassium gluconate.)

During the protein sparing modified fast, the protein that is least needed by the body (i.e., protein used to make metabolic enzymes and cells of the small and large intestines) is utilized to provide glucose for the brain, thus sparing the more necessary proteins in other parts of the body. As a result, when re-feeding is attempted, the gastrointestinal system is not prepared. Re-feeding must be undertaken with extreme care. Carbohydrates must be avoided since they stimulate the secretion of insulin, which then shuts off the only supply of energy available, fat. In addition the re-feeding period is an ideal time to implement behavioral modification techniques. The patient who attempts this diet on his/her own misses the opportunity to get to the bottom of the problem itself and change the basic habits and attitudes towards eating and physical exercise which caused the obesity in the first place. Such an individual has a very high likelihood of gaining back every bit of weight lost.

Alcohol, in addition to containing seven unneeded calories per gram, inhibits antidiuretic hormone secretion, resulting in a diuresis which may aggravate existing dehydration. Since the patient gets no vitamins from the liquid protein supplement, a mult-vitamin preparation must be provided. Extra thiamine is also required during the re-feeding period. Calcium and phosphorus supplements are required by most people who take this diet.

Contraindications

As mentioned above, this diet is contraindicated in gout and cardiac patients. It is absolutely contraindicated in patients taking phenformin; it is relatively contraindicated in diabetics. The effects of this diet on the fetus have not been studied, but would be expected to be negative; therefore, the diet should be considered contraindicated in pregnancy. It is also contraindicated in patients with kidney or liver dysfunction.

The Last Chance Diet, or protein sparing fast, is a relatively untried regimen. The discoverers of the diet themselves have recently voiced serious concerns over the lack of sufficient long-term studies to determine its safety and efficacy.[3] It would thus be prudent for the lay person not to undertake such a diet unassisted. It would also be wise for the pharmacist to warn his/her patients about the inherent dangers of the diet.

References

1. Flatt, J. P., and Blackburn, G. L.: "The Metabolic Fuel Regulatory System," *Am. J. Clin. Nutr.* 27:175-87 (Feb) 1974.
2. Blackburn, G. L., *et al.*: "Restoration of the Visceral Component of Protein Malnutrition Using Hypocaloric Feeding," *Clin. Res. 23:* 315A, 1975.
3. Cowley, S. C. and Sethi, P. J.: *Newsweek*, July 11, 1977, p. 74.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Nonobstructed urinary tract infections (mainly cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staph. aureus, P. mirabilis, P. vulgaris).* **IMPORTANT NOTE: *In vitro* sensitivity tests not always reliable; must be coordinated with bacteriological and clinical response. Add aminobenzoic acid to follow-up culture media. Increasing frequency of resistant organisms limits usefulness of antibacterial agents, especially in chronic and recurrent urinary infections.** Maximum safe total sulfonamide blood level, 20 mg/100 ml; measure levels as variations may occur.

Contraindications: Hypersensitivity to sulfonamides; infants less than 2 months of age; pregnancy at term and during the nursing period.

Warnings: Safety in pregnancy not established. Do not use for Group A beta-hemolytic streptococcal infections, as sequelae (rheumatic fever, glomerulonephritis) are not prevented. Deaths reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. CBC and urinalysis with careful microscopic examination should be performed frequently.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma. Hemolysis, frequently dose-related, may occur in glucose-6-phosphate dehydrogenase-deficient patients. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; *Miscellaneous reactions:* Drug fever, chills and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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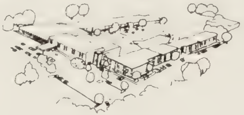

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Usage in pregnancy: Safe use not established. Should not be used in pregnant women unless potential benefits outweigh possible hazards.
Precautions: *Head injury and increased intracranial pressure:* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
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Special risk patients: Administer with caution to certain patients such as the elderly or debilitated and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.
Adverse Reactions: Most frequent: lightheadedness, dizziness, sedation, nausea and vomiting; more prominent in ambulatory than nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Others: euphoria, dysphoria, constipation and pruritus.
Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.
For information on symptoms and treatment of overdosage, see full prescribing information.

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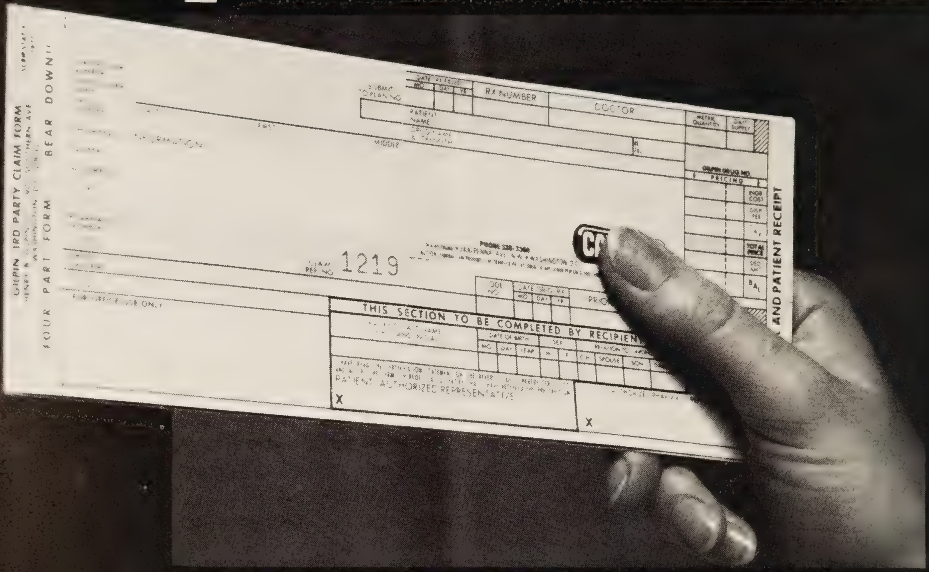
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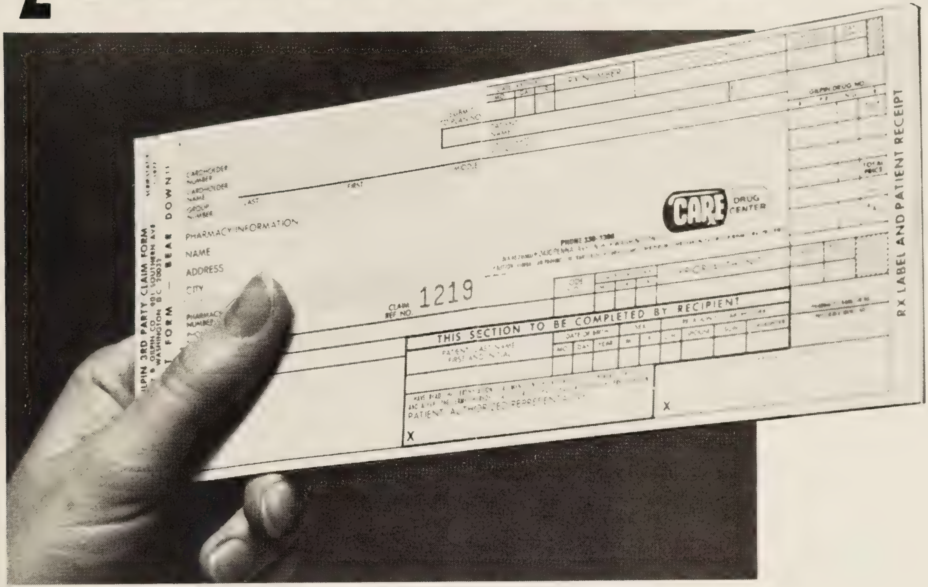
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C 1

Pharmacy and Industry — Facing the Future Together

By C. Joseph Stetler*

Mr. Chairman, Ladies and Gentlemen:

It is a distinct pleasure to be here this evening and I am indebted to Nate Gruz and George Stevenson for the invitation. Giving this talk at Ocean City gave me a perfect excuse for two days' vacation, and for that my wife thanks you too, and two of my daughters who are here with us also thank you.

Deciding on a subject for a banquet speech isn't easy if you're not an entertainer and, believe me, I'm not. In contemplating it, I became somewhat envious of the cross-eyed javelin thrower. As the man said, he didn't win many Olympic medals, but he sure kept the attention of the crowd.

To help me out, Nate suggested the title "Pharmacy and Industry — Facing the Future Together." I agreed to that since it gives me a lot of leeway in commenting on a subject that I live with every day — that is our mutual problems, emanating from Washington.

I have been involved recently in a number of state and national meetings with pharmacists and I am delighted with the tremendous improvement in the rapport between your profession and the industry which I represent.

A couple of years ago, at just about the same time, industry and pharmacy recognized the lunacy of the "self-destruct" policy we were both following and resolved to effect a change.

Some very honest effort and hard work by industry and pharmacy leaders have resulted in a marked improvement in relations and communications. And, although some major differences still exist, we have, with a new recognition of the other's point of view, made great progress; and we stand an excellent chance, in the years immediately ahead, of accomplishing some real good together.

Speaking for prescription drug manufacturers, I can tell you that these are very busy times for us in Washington, just as they have been for the past decade. During this last year alone, we commented seventeen times on FDA proposed regulations, and testified at least a dozen times before Congressional Committees, most recently on the swine flu fiasco, recombinant DNA research and the saccharin ban — all items unforeseen when the year began.

In fact we have had pretty much a continuation of the same wide-ranging contest with government that we've had ever since 1959 when the Kefauver drug hearings began.

I guess it should surprise no one, therefore, after almost 20 years of jousting with government, that a degree of cynicism has developed. I know I found myself very much in agreement with George Will, a columnist who spoke at our Annual Meeting in April, when he described the three most discredited sentences in common use today as:

(1) The check is in the mail;

(2) Certainly, I'll respect you as much in the morning as I do tonight; and

(3) I'm from the government and I'm here to help you.

Speaking of the government, one of our companies was contacted recently by the Office of Equal Opportunities and asked for a list of employees "broken down by sex." The man who responded said, "That really isn't our problem. It's mostly drugs and alcohol."

For a switch, let me talk about one of the most serious subjects I can think of — federal legislative activities. As drug industry representatives, we are called upon to make an uncommon number of appearances, mostly before committees chaired by Senator Edward Kennedy and Representative Paul Rogers. We, in industry, recall the Senator's speech at the APhA annual meeting in 1973 with very little pleasure. At that time, he announced that he was about to begin an extensive Congressional investigation of our industry and that he had major, virtually convulsive, reforms of our industry in mind.

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*Presented by: C. Joseph Stetler, President, Pharmaceutical Manufacturers Association, Maryland Pharmaceutical Association Convention, Ocean City, Maryland, June 21, 1977.

It seems fair to say, at this stage, that his hearings, which began in July of 1973, have probably disappointed the industry's more strident critics. While he has given platforms to a substantial number of our antagonists, including those who contend that this nation is suffering a plague of adverse drug reactions, he also stopped short of an unqualified acceptance of their charges. Instead, he challenged us in a speech at our Annual Meeting in 1976 to create a mechanism which could objectively define the problem, design a means of resolving it, and produce a system for monitoring drug utilization in the United States.

"MAC remains what it was at its birth — a misfit . . ."

Our response to that challenge was to join with pharmacy, medicine, and with hospital and consumer representatives in the creation of the Joint Commission on Prescription Drug Use. I am happy to tell you that the APhA and the American Society of Hospital Pharmacists are active participants in that effort.

Earlier the Senator had given serious attention to the question of excessive promotion in the industry, airing charges alleging excessive sampling, that gifts were being given to medical and pharmacy practitioners, and that patient privacy was being threatened when drug firm employees conduct prescription surveys.

In response we set up a series of guidelines and recommendations to discourage such practices and endorsed legislation which would limit existing excesses.

These and other experiences have convinced us that industry and its constructively motivated critics can find grounds for accommodation. In addition to the new Commission, we have worked effectively with Congressman Rogers and Senator Kennedy on the preparation and enactment of the 1976 Medical Devices Amendments. We are now working toward a practicable legislative solution to the control of recombinant DNA research, with passage of a bill probable before the August recess. And we hope to take a constructive and aggressive role in the forthcoming hearings on drug industry prices, profits and patents which are scheduled to begin on July 14.

Senator Kennedy has an omnibus bill, to be introduced this month, which reportedly is a very comprehensive measure, designed to restructure the FDA for the first time in 15 years, and reform major aspects of our marketing practices. There will undoubtedly be features of this proposal which are unacceptable to us and to pharmacy.

I suppose some of you have read or at least heard about Senator Kennedy's speech last month before the graduating class at the Massachusetts College of Pharmacy. He had some nice things to say about pharmacy and although he threw industry a few bouquets, he made it clear that we were "still in his sights" and that more hearings are in the offing.

So, Senator Kennedy has not exactly become our ally on Capitol Hill. Nor have we capitulated to him. The same point could be made with respect to Congressman Rogers. Yet, in both of these men, we are fortunate to be dealing with very intelligent and responsible legislators. They do not accept *our* every contention. But they also will not endorse every idea from the Administration or from the Nader camp either. They give us adequate opportunity to make the best case we can. If our views are cogent, they have a good chance of prevailing, and that is all we really ask for or need.

Let me comment briefly on a couple of other matters of mutual concern, namely our old "friend" MAC (the HEW Maximum Allowable Cost Regulations), the proposed ban on saccharin, and the patient package insert, which could be a bonanza for the printing industry and a headache for you, the doctor and the drug industry.

MAC remains what it was at its birth — a misfit that threatens to grow into a disruptive and expensive experiment in the name of cost control. It's like an oil spill, dumped by people who have long ago abandoned ship, drifting from place to place. It won't sink, it won't burn, it just oozes around the bureaucracy.

As we have said repeatedly, in every forum at our disposal, we simply do not accept the MAC assumption that the marketplace functions poorly or that physicians and pharmacists make inept professional decisions — and therefore, that government must step in to correct matters. This approach is repugnant to manufacturers, as it surely must be to the independent pharmacist both as a businessman and as a professional.

"The Patient Package Insert [is an] idea whose time has come."

We lost our lawsuit challenging the program, but we have not resigned ourselves to a lifetime with these regulations. We will be filing a formal petition with HEW soon seeking some important changes in the present approach.

Saccharin is, of course, a hot topic of debate these days, but with Congressman Rogers and Senator Kennedy in agreement, it seems reasonably certain that the Congress will pass legislation deferring the proposed ban for 18 months, while additional studies are conducted.

But the saccharin mess merely illustrates a really strange phenomenon in this country, that is, a growing irrationality in our government's policies toward certain kinds of risks.

(Continued on page 21)

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—
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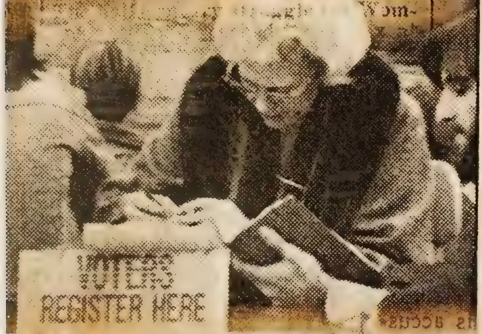

Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,00
Persons When States Adopt Cooperating Laws—He C
the Measure 'Cornerstone' of His Economic Progra

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen[illegible]

WASHINGTON, Aug. 14
The Social Security Bill, pr
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TRUMAN CLOSES
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CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

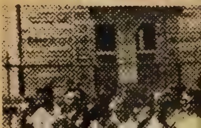
Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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Pharmacy and Industry

(Continued from page 17)

Last month a reporter for the *Washington Post* wrote a very interesting story which illustrates my point. "In 1976 alone," he found, "*The Washington Post* carried stories linking cancer-causing agents to various drugs, sex hormones, beef, chicken, swine and turkey, over-the-counter medications, cough syrup, toothpaste, food packages, flea-collars, sleepwear, snuff, X-rays, herbicides, pesticides, decaffinated coffee, bacon, Red Dye No. 2, various workplaces, air, drinking water and, would you believe, 'mother's milk'?"

Obviously, we're overdue for a re-thinking of our conception of the notion of safety. It just may be that saccharin is the product to force such a re-evaluation.

Now let me touch briefly on the patient package insert, an idea whose time has come, in our opinion. Properly handled, it offers a long list of potential benefits to medicine, pharmacy, the industry and the patient.

However, it also raises many serious questions, particularly as currently proposed by the FDA with respect to the estrogen products. We see some important legal implications in these regulations and the potential establishment of a very dangerous precedent.

"[Substitution law changes] have resulted in loss of professional stature by both pharmacists and physicians."

We have been authorized by our Board of Directors, to question the proposal in court when it is finally promulgated, if existing difficulties are not resolved. An amicus brief will be filed by the AMA, and I am happy to report, by APhA as well. The chances of winning this lawsuit will be improved immeasurably with industry, pharmacy and medicine taking a common position and approach.

No discussion between drug industry and pharmacy representatives would be complete these days without commenting on substitution.

As one state after another modifies its antisubstitution laws a hodge-podge of new statutes is emerging. However, I am not at all certain that these changes can be called "victories" by anyone. Physicians, pharmacists, the public, and manufacturers, in my opinion, have all been losers. To our knowledge the changes adopted have not brought about any significant consumer savings, but instead have resulted in a loss of professional stature by both pharmacists and physicians.

Whatever the outcome of these state activities, however, I assure you that our position on substitution is no disparagement of pharmacy either professionally or economically. Our differences on this proposition aside, we see the professional role of the pharmacist becoming more important in tomorrow's health care system, without repeal of state antisubstitution laws or regulations.

Before closing, I would like to mention a couple of projects and some progress in the area of public relations. We have tried recently to put more fire power into our public messages, to broaden our press contacts, whenever possible to take part in both network and local TV and radio programs, and in general to make ourselves more accessible to the news media. These efforts, for the most part, have been gratifying.

We plan to continue to utilize print advertising to explain key industry positions. As you may have noticed, we have also tried to emphasize the important role of the pharmacist. In this connection, I want to thank you for the action taken by your Association on April 21 in commending the PMA for our "lifeguard" ad which has appeared in national magazines and will be run again, probably this fall.

As I mentioned initially, our increased liaison with pharmacy has had particularly gratifying results. I can assure you that we intend to work diligently at further improvements. It would be extremely short-sighted for any of us, to let differences obscure our basic objectives, which are and must remain a joint venture, with medicine, and an increasing partnership with government, in bringing quality pharmaceutical services to people. The measure of how well we perform in the future will depend on how well we keep the team approach in balance.

And keeping that balance is going to require increasing attention. Whether there is in fact a real health care crisis in America today can be debated, but there isn't much doubt about a bureaucratic crisis — the ever-encroaching arm of the government into the system, along with the threats and promises of much more to come, some of it subtly and indirectly, some of it with blunt force. And this is why pharmacy and industry must be allies, not only for self-preservation and some measure of freedom in conducting our affairs, but in order to serve the public interest.

Thank you for the opportunity to be with you this evening and for your fine Maryland hospitality.

calendar

- Nov. 3 — BMPA Executive Meeting — Suburban House
- Nov. 4-6 — AZO Fraternity Regional Convention, Lord Baltimore Hotel
- Nov. 10 — BMPA Annual Meeting, Quality Inn, Pikesville
- Nov. 20 — Alumni Association Open-Pit Bull & Oyster Roast
- **Jan. 7-15** — M.Ph.A. Winter Trip to Martinique
- Feb. 12 — BMPA Annual Installation Dinner Dance — Blue Crest

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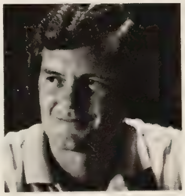
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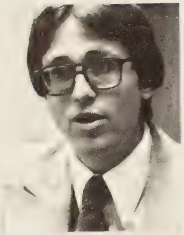
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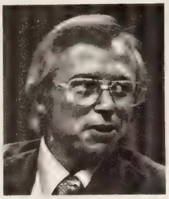
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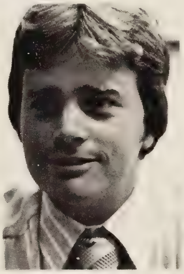
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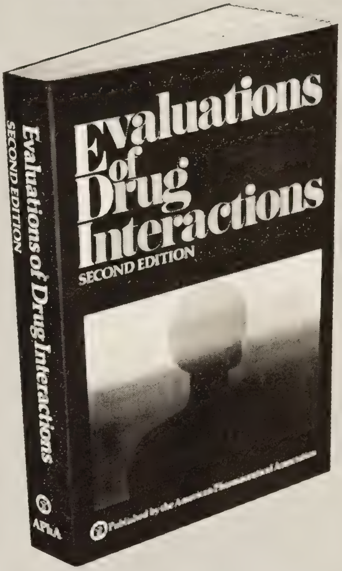
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"Another Economic Phase of Pharmacy"

Taken From: *The Maryland Pharmacist* — Volume 1 — Number 4
Editor: R. L. Sawin — January 1926

There has been much discussion in recent months about the increase in the number of retail drug stores, and the thought has been suggested that the growth is faster than is required and that new stores are being opened more rapidly than they can be legitimately supported, and because of this disturbance of economic equilibrium, many distressing conditions, such as *price cutting*, violations of the pharmacy laws and illicit dealing in intoxicants has been the logical result. Whether or not such conditions have resulted, and whether or not the increase in the number of retail stores is directly responsible for them, is for the time being beyond the purpose of this short paper. However, a study of the number of retail drug stores as they apply to Baltimore will be of interest and will supply much material upon which a more serious study of the entire matter may be based.

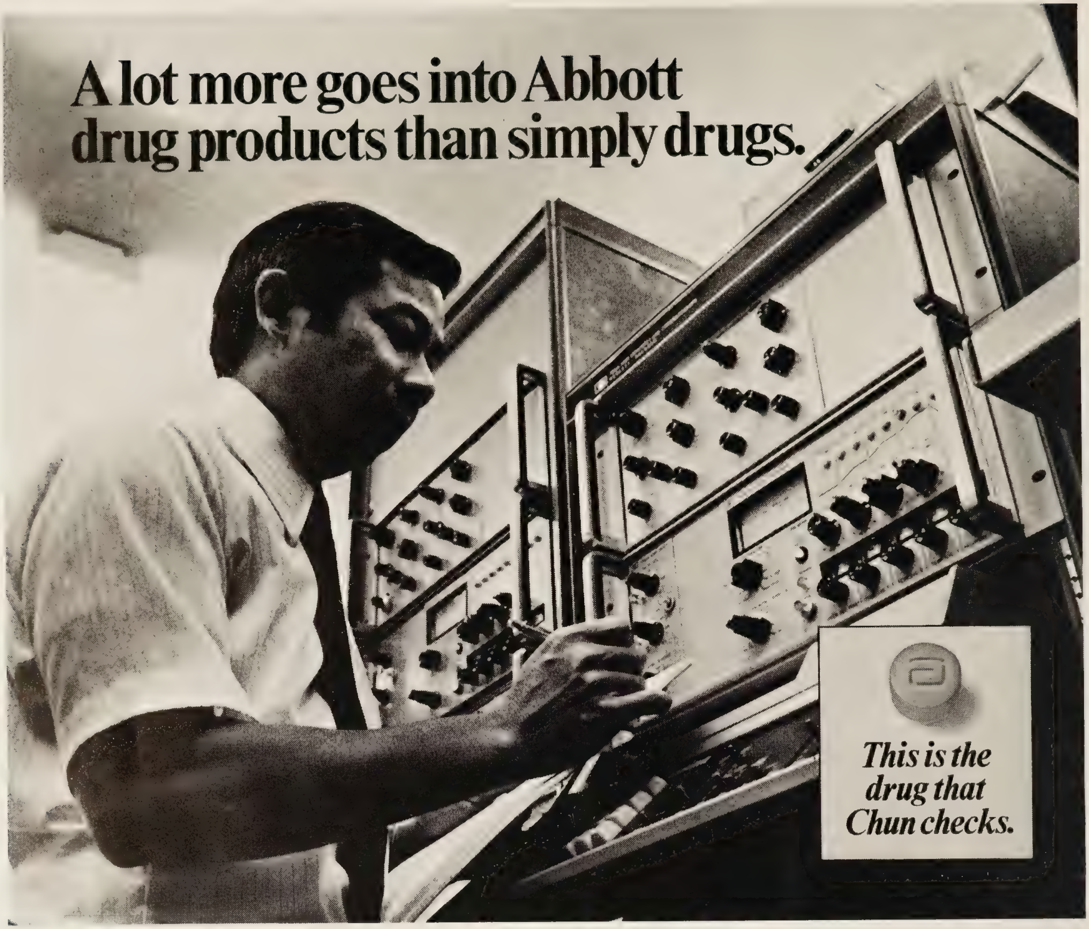
According to the figures furnished by the Department of Health of Baltimore City, the population of the city was on January 1, 1925 789,197. The files of the Bureau of Food and Drugs of the State Department of Health, which agency is charged with the enforcement of the pharmacy laws and maintains a close connection with retail pharmacy, showed 377 retail drug stores in the city of Baltimore on January 1, 1925, and from these figures it is easily ascertained that the ratio existing between the total number of stores to the population was 2,093; or in other words, every drug store in Baltimore had as an average 2,093 patrons. The year just past, shows figures somewhat different. The Department of Health of Baltimore gave the population of the city as 800,555 on December 31, 1925, and the official record of the number of retail drug stores shows the total for Baltimore to be 407, a net gain of thirty for the year. Applying the same method as before, we find the ratio between stores and population to be 1,967 which is simply another way of saying that every drug store in Baltimore must do business with an average of 126 less patrons than a year ago. The growth of Baltimore is given for the year as approximately a thousand persons per month, or twelve thousand a year. The increase in population would have had to reach about 60,000 to maintain the same store-population ratio. Based on the official figures, the increase in the number of drug stores, normally required to maintain the ratio per store now existing, is about six per year. The mere fact that the increase in the number of retail drug stores in the past year was five times as much as was required to keep up with the increase in population may merit the deepest study on the part of retail pharmacists, and may well give pause to those who contemplate opening new stores.

Knife Wound Bleeding Controlled With New Technique

Emergency surgery is commonplace in a large metropolitan hospital such as Roosevelt Hospital in New York City. Although physical violence is reported in daily newspapers as crime, on hospital records the results of such assaults may be described as traumatic, life-threatening injury, requiring highly skilled operating room techniques.

At Roosevelt Hospital, a victim was rushed to surgery, having sustained a stab wound of the neck with severance of the vertebral artery at the base of the neck and laceration of the jugular vein. Walter A. Wichern, Jr., MD, Chairman of the hospital's department of surgery, reports that pressure and conventional hemostat were repeatedly applied but were ineffective in controlling the hemorrhage. Then a new hemostatic agent, Avitene (microfibrillar collagen hemostat), was applied to the area which resulted in an immediate cessation of bleeding. "No recurrence of bleeding developed in the immediate or post-operative period," according to Dr. Wichern. Subsequently, success was also achieved with the new agent in instances of stab wounds to the liver.

More recently, Avitene was described as a major advance in surgery in a recent article in *Modern Medicine*.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Pharmacy and Law

A Case of Equanil Withdrawal

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In October 1960, Mrs. Wilmoth Johnson received a prescription from her physician for Equanil to relieve muscle spasms. The prescription was for 24 tablets, to be taken three times a day after meals. The defendant pharmacist filled the Rx as instructed. In November, Mrs. Johnson requested a refill, and the pharmacist phoned the physician to determine if he was authorized to refill the prescription. The physician said that Mrs. Johnson could "have a few along as she needs them." The pharmacist then marked the prescription "P.R.N.", or refill as needed. Early in 1961, the pharmacist suggested to Mrs. Johnson that because she was taking Equanil regularly, it would be less expensive if she bought in lots of 100 tablets. By the middle of 1961, Mrs. Johnson had increased her dosage to 7 to 10 tablets per day. It was undisputed that every container sold by the defendant was labeled with the directions that the drug was to be taken three times a day after meals. In 1962, Mrs. Johnson underwent treatment for "withdrawal" from the use of Equanil. She convulsed for six hours and also suffered brain and liver damage from the prolonged use of the product.

The issues in the case were as follows: (1) Was the increasing of the dosage by Mrs. Johnson the proximate cause of her injuries, or was the sale of Equanil in 100 tablet lots rather than 24 the proximate cause, and (2) Was Mrs. Johnson's violation of the doctor's directions contributory negligence that caused the injury, thereby barring recovery? The trial court felt there was no genuine issue of fact and that the affidavits and depositions before the court were sufficient to establish contributory negligence on the part of Mrs. Johnson which precluded any recovery on her part. Therefore, the court granted a summary judgment in favor of the defendant.

The appellate court disagreed on the basis that one of the physicians involved in the case stated in his affidavit that Equanil tends to destroy the recipient's power to resist, and that it is habit-forming when taken in any quantity. The general rule is that a careless plaintiff may not recover damages even when a defendant is at fault in supplying the condition without which the injury would not have occurred. However, if the plaintiff was deprived of her will power and was so addicted to the use of Equanil that she could not control her conduct, there would be a real question of whether her acts could be classed as contributory negligence. Because of this issue of fact, the case was reversed and remanded to the trial court for a complete hearing. *Johnson v. Primm*, 396 P. 2d 426 (1964).

Unfulfilled aggressive drives can lead to the development of untreatable pain, researchers report. They can literally become "a baffling pain in the neck."

— Medical Digest
reported in AFP
Vol. 16, No. 1

A new experimental screening technique for early detection of lung cancer in smokers, before symptoms appear, promises a better cure rate for lung cancer victims.

— Medical Tribune, 6/8/77

"Americans suffer from a personal and institutionalized prejudice against older persons," according to the director of the National Institute on Aging, who urged that geriatric medicine be introduced into the curriculum of medical schools, intern and residency training, and into programs of continuing education.

— Psychiatric News, 5/20/77

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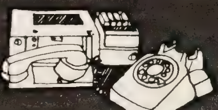

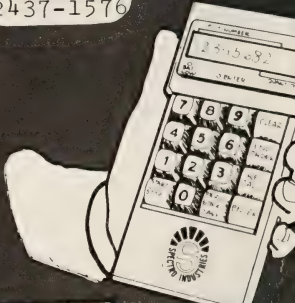

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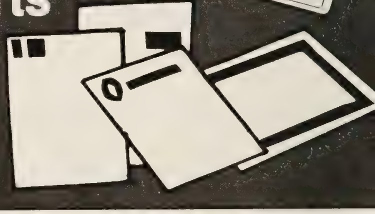

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Drug Product Problem Report

The case studies presented below are intended to serve as examples of the kinds of action that may be taken through the Drug Product Problem Reporting Program. While these results are from actual reports received, they are included for general illustrative purposes only. It is hoped that these examples will indicate to the pharmacist reader some of the areas where he or she may want to be alert. No reflection on any specific manufacturer, distributor, pharmacist, or product is intended or should be inferred from the case studies.

A. Weight Variation

Weight and fill variations were reported in one lot of Diphenhydramine Hydrochloride Capsules by a pharmacist at a health center in Illinois. Analysis of the lot mentioned in the report and of another lot by the FDA revealed that both failed to meet USP content uniformity specifications. The firm recalled the lots involved.

B. Full Disclosure Under Closure

A Missouri community pharmacist reported that while the labels of two strengths of a nitroglycerin product instructed the pharmacist to dispense only in original unopened containers, the professional information insert was packaged under the safety seal. This made it impossible to dispense unopened bottles of the product. The manufacturer thanked the pharmacist for calling it to its attention, acknowledged the inconsistency, and is altering its packaging operations so that the required insert will be attached to the outside of the bottle.

C. What Percent?

Pharmacists nationwide submitted Drug Product Problem Reports commenting on the failure of a label to indicate the concentration of the hydroxypropylmethylcellulose present in an over-the-counter ophthalmic solution. The product is frequently prescribed by designation of its active ingredient and strength, and problems were created because the strength information was not readily available. The company responded that since it was not required by Federal regulation to list the concentration, it had omitted the declaration. However, since it received several questions regarding it, it has decided to show the concentration on both the label and insert of future lots.

D. Not I.V.

A hospital pharmacist in Mississippi reported that a salt solution used for irrigation purposes in ophthalmic surgery had the appearance of a product intended for I.V. use. He suggested that the label should prominently state that the product was not intended for intravenous use. The company thanked him for calling it to their attention and responded that, effective immediately, a red over-lay sticker stating "Not for I.V. Use" would be utilized.

E. Upset Antacid

A California community pharmacist reported that a batch of an aluminum-magnesium hydroxide suspension was a dirty brown or tan color instead of white and that some patients had complained of the taste. Upon receiving the report the firm voluntarily destroyed what they had on hand of the reported lot, but did not recall it at that time. However, at an inspection of the firm at a later date, FDA was advised that another lot was retested and that high coliform growth was found. An FDA market survey following this revealed sizeable quantities of both this lot and the one mentioned in the pharmacist's report on retail shelves. When informed of the results of FDA's survey, the firm elected to recall both lots.

F. Metallic Injection

A pharmacist in a Wisconsin hospital reported the presence in a synthetic penicillin injectable of silvery, dark particles that would not dissolve upon reconstruction in vials. During a follow-up inspection, FDA learned from the manufacturer that they had evaluated a sample from the pharmacist and had determined the particles to be metallic and had traced them to a powder filling machine. The firm modified the filling equipment in an effort to eliminate this problem.

G. Tiny Type Hyped

A Chicago hospital pharmacist reported that nurses had complained to him that the printing stating the concentration after reconstitution of an ampicillin oral suspension product was too small and difficult to read on the dark background. The company has responded indicating that the type size used for printing the labels will be increased for better clarity.

H. Anonymous Aspirin

"There is no mention of the aspirin content" was the comment received from an Illinois hospital pharmacist regarding the label of a unit dose packet of an analgesic containing Aspirin and Codeine. The manufacturer has indicated that it plans to add the aspirin declaration to future unit dose packages of the product.

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(Required by 39 U.S.C. 3685)

1. TITLE OF PUBLICATION Maryland Pharmacist	A. PUBLICATION NO.	2. DATE OF FILING 10/26/77
3. FREQUENCY OF ISSUE monthly	A. NO. OF ISSUES PUBLISHED ANNUALLY 12	B. ANNUAL SUBSCRIPTION PRICE $10.00

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650 W. Lombard Street, Baltimore, Md. 21201

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EDITOR *(Name and Address)*

David A. Banta, 650 W. Lombard Street, Balto., Md. 21201

MANAGING EDITOR *(Name and Address)*

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N.H.I. — Take It or Leave It?

Remarks
by
RICHARD D. PARKER
President, Maryland Pharmaceutical Association
Before Region III HEW
On National Health Insurance
October 19, 1977

My name is Richard Parker and I am President of the Maryland Pharmaceutical Association. The Association is the state society of pharmacists representing approximately 1,000 members in all phases of pharmacy practice in Maryland.

We sincerely appreciate this opportunity to present our remarks to you today on the subject of National Health Insurance.

We believe that some form of National Health Insurance is necessary, especially to provide coverage for out-patient prescription medications to those elderly citizens who are not covered by Medicaid. While we recognize this need, we hope that HEW will not change the traditional methods of health care delivery in this country simply for the sake of change, but rather, will take appropriate action to address the problems with a minimum of disruption to current procedures.

Let me preface my remarks by saying that I will be speaking to you from a practitioner's point of view on behalf of the state association. I cannot address many of the points you have outlined in the background paper which accompanied your invitation; especially those points involving philosophical approaches to the format of National Health Insurance. I will, instead, try to convey to you the hopes and fears of many of my colleagues, as I have interpreted them, concerning this subject.

Most pharmacists base their present opinions of National Health Insurance upon their experiences with Medicaid and other Third Party Programs. Since the advent of these programs in the late sixties and early seventies, the delivery of pharmaceutical services has been drastically altered from its earlier traditional format.

It is our hope, that many of the problems involving pharmacy practice that have arisen during this time period will *not* be allowed to find their way into an eventual National Health Insurance program. Modern health care treatment is intimately tied to drug therapy. The proper utilization of drugs is the primary method for treating disease and injury.

Therefore, I think it is obvious that Pharmaceutical Services *must* be included under National Health Insurance coverage. By Pharmaceutical Services, I mean more than merely drug dispensing. Other services, such as patient medication records, patient consultation, drug utilization review and other services should be included under the term "Pharmaceutical Services." These services must be recognized and reimbursable under NHI. The profession of pharmacy is currently expanding the scope of care under the practice of pharmacy within the health care team concept. Recognizing and encouraging these services will provide for greater efficiency and savings to all health care programs.

Pharmacists are wary of the logistical and administrative burdens that will accompany National Health Insurance. Many pharmacy providers are small businessmen, already buried under a mountain of bureaucratic paperwork from other third party programs. NHI forebodes more of the same. Pharmacists cannot tolerate a system which delays payments, fails to update costs and in general is unresponsive to the individual practitioner. This has been our experience in the past and there is very little to suggest that NHI will be different.

Our further experience with the HEW's MAC and EAC program strongly suggests that more money will be wasted trying to determine costs than to contain them. In this we are speaking not solely as the providers directly affected by this bureaucratic inefficiency, but also as taxpayers.

Another fear that pharmacists have involves the "take it or leave it" nature of most Third Party Programs. Many pharmacists are experiencing severe financial hardship because of the universal exclusiveness of third party programs and their low dispensing fees. Of course, it can be argued that pharmacists have the choice of *not* participating in a program with marginal dispensing fees, but when that program represents a prohibitive share of the total market available to the pharmacists, *then there is no real choice*. In spite of this, many pharmacists are resigning from third party programs including Medicaid programs, in protest over inadequate program conditions and dispensing fees. Since National Health Insurance will represent an even larger share of the market available, it is easy to understand why pharmacists are concerned.

In the past, pharmacy dispensing fees have been arbitrarily set, and for the most part, have not kept pace with rising expenses to the pharmacist. While HEW has recently mandated that Medicaid officials conduct dispensing fee surveys, it has not seen fit to mandate that these fees be a realistic reflection of actual costs. Pharmacists are worried that this same unresponsive attitude by HEW will continue when the dispensing fee is controlled by HEW.

Pharmacy's current battle against inadequate dispensing fees by third party carriers is well known to us all. Experiences with the MAC and EAC program tell us that the philosophy of utilizing averages to determine a universal program figure can be dangerous. Obviously, a single, average dispensing fee under National Health Insurance will overcompensate some practitioners and at the same time, undercompensate the rest. On the other hand, logistical considerations prevent HEW from negotiating with each individual provider. Dispensing fees must take into account varying expenses between

(Continued on page 36)

Photos courtesy of Paramount Photo Service

On October 19, 1977, representatives from the M.Ph.A. met with officials from Region III HEW to discuss the subject of National Health Insurance. Pictured above are (from left to right): George Maycock and Tom Bair, HEW; David Banta, Executive Director M.Ph.A.; Richard Parker, President M.Ph.A.; Henry Seidman, Past President M.Ph.A., and Samuel Lichter, Speaker of the House. Donald Fedder participated but is not pictured.

(Continued from page 35)

practitioners, allow for reasonable profit, and provide for changes in business factors such as inflation. This area deeply concerns pharmacists because of their bad experience with other government and third party prescription plans. It is currently a fact that in many pharmacies, private pay patients are subsidizing the pharmacist's participation in Medicaid programs because of the inflexible and inadequate dispensing fees.

Many pharmacists have called for an anti-trust exemption, so that we can get away from the "take it or leave it" nature of these programs, and negotiate agreements on an individual basis. This could even be accomplished by providers within existing association structures.

I believe that this major problem area must be fairly resolved if we are to secure widespread pharmacy provider participation in NHI. Pharmacists have been hurt by previous programs and are not likely to leap at another major third party innovation until they are completely reassured as to its equitability.

We realize that pharmacy services under NHI will represent a high number of individual claims involving a relatively low dollar amount within the program. However, the administrative problems associated with processing these claims *must not* be allowed to delay payment to the pharmacist.

In the past, pharmacists have been caught in the middle when verification of eligibility was required. It takes time and money, which in the past has not been reimbursed, for the pharmacist to perform this function for the program. In some cases, he has risked losing the goodwill of the patient and either denial or delay in payment for services.

As you know, pharmaceutical products are currently going through a period of rapid price escalation by the manufacturers. Steps must be taken to insure that these prices are updated in a timely fashion.

In many states, including Maryland, pharmacists and consumer groups have succeeded in repealing the so-called "anti-substitution" laws. We believe that an eventual National Health Insurance program should allow pharmacists to exercise their professional judgement in drug product selection. There should be some incentives to allow pharmacists to hold down product costs while acting as a purchasing agent for the program.

We are also concerned that the principle of freedom of choice be preserved. As in the past, the patient must be allowed to determine the source for pharmaceutical services on an individual basis.

In conclusion, I am pleased to extend to you the resources of the Maryland Pharmaceutical Association whenever we may be of assistance to you. We appreciate this opportunity to supply input into the deliberation process involving National Health Insurance. While we have several reservations concerning many of the program's eventual features, we are willing to work with you to insure that National Health Insurance is equitable to pharmacist providers, and serves the welfare of the citizens of America.

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LETTERS

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October 13, 1977

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MILLER DRUG SUNDRY COMPANY

On August 1, 1977, William Weiner, formerly with Reads' Drug Stores, joined with Calvert. He has been elected a Vice President of the company and will be responsible for all purchasing, and also direct the Astro advertising cooperative program. He is currently the president of the Alumni Association of the School of Pharmacy.

Guide To Good Pharmacy Management
Merchandising
Guide To Good Pharmacy Management
Merchandising

Availability of *Merchandising*, the third volume in the widely acclaimed "Guide to Good Pharmacy Management" series, has been announced by Roche Laboratories and the National Association of Retail Druggists. This issue continues the original innovative concept of providing practical information on business principles which has been so well received by the Nation's pharmacists.

With distribution to the pharmacy audience planned for October 1977, *Merchandising* addresses the essential criteria for integrating the professional and business functions which result in the movement of goods. The text discusses both marketing and merchandising concepts and their relationship to alternative operating philosophies and the competitive environment. Included for the pharmacist's consideration are discussions of how these principles may be effectively implemented through store layout, promotions, and pricing strategies. Relevant diagrams and work sheets are provided to assist the pharmacist in applying merchandising principles. Subsequent issues will explore other important topics as identified by practicing pharmacists, businessmen and educators.

These will be made available to pharmacists and pharmacy schools as a service from their local Roche representative. Inquiries should be directed to the local Roche representative; or to J. Breitman, Roche Laboratories, Nutley, N.J., 07110; or to the NARD, 1750 "K" Street, N.W., Washington, D.C., 20006.

- CLINDAMYCIN TOPICALS. Many dermatologists are writing prescription orders for an acne preparation consisting of clindamycin hydrochloride and alcohol. Many pharmacists have attempted to use prefabricated capsules as the source of the antibiotic but have found that a residue remains in the preparation. According to Dr. Frederick P. Siegel of the University of Illinois Medical Center, if the residue is filtered off, an efficacious preparation will result. Clindamycin hydrochloride is *freely soluble in water and alcohol* — the undissolved residue represents inert ingredients in the capsule filler.

Some pharmacists have attempted to solve the "insolubility problem" by using clindamycin phosphate injection instead of the hydrochloride salt. However, Dr. Siegal cautions, "The pharmacist should be alerted that this form of clindamycin is not a simple salt as is the hydrochloride. The phosphate, in contrast, is an ester derivative solubilized as the salt. Whereas the hydrochloride is active as such, the phosphate is inactive . . . The enzymes required for the hydrolysis of the phosphate are lacking via the dermatological route. Consequently, the phosphate demonstrates poor *clinical results* for topical application to the acne lesion. *PHARMACY PRACTICE, VOL. 12, NO. 7.*

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On September 27, 1977, BMPA hosted an open forum for M.Ph.A. and BMPA members on the Pharmacy Practice Act revision. Pictured above is part of the crowd which suggested changes in the Act. At right, BMPA President Stanley Yaffe opens the meeting.

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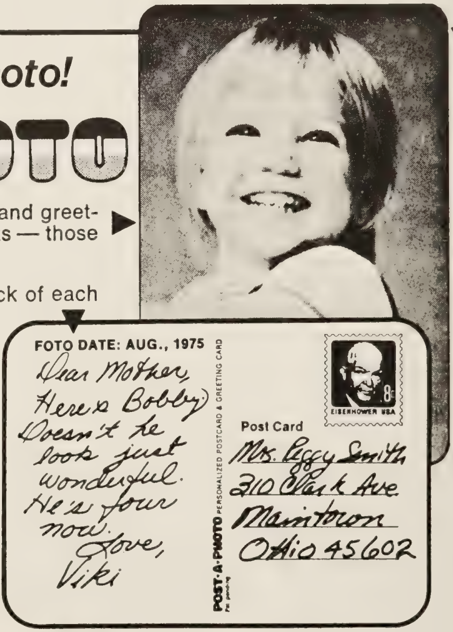

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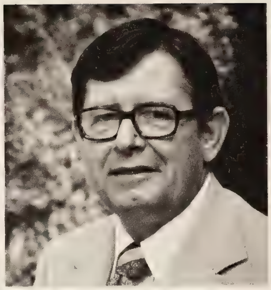
Professor of Hospital Pharmacy
Chapel Hill, N.C.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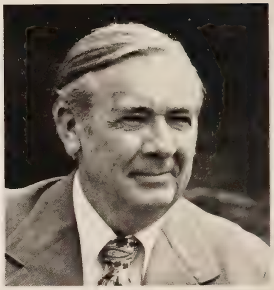
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THE
MARYLAND
PHARMACIST

Official Journal of
The Maryland
Pharmaceutical
Association

DECEMBER, 1977
VOL. 53
NO. 12

The New Drug Product Selection Law

Two Proposed Amendments to the Pharmacy Practices Act

"From the Consumer's Point of View"

– Estelle Cohen

THE MARYLAND PHARMACIST

650 WEST LOMBARD STREET
BALTIMORE MARYLAND 21201
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DECEMBER 1977 VOL. 53 NO. 12

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President's Message

A Look at Pharmacy from the Outside

Chief Justice Warren Burger compared today's pharmacist with the clerk in a law book store. How far he has strayed from reality. Now as we start to question the practice of polygraph testing, we are grouped in a class with gas station attendants and bartenders as likely crooks. With the advent of self-service and discount pharmacy, we have lost the respect of the average consumer and there is a definite need to demonstrate how really professional we are. Certainly we are being given more recognition by the government and by the allied health care professionals.

To broaden this image, we must project to the consuming public, our patients, the extensive knowledge we have and our vast experience in the field. We must adopt a program to provide continuing competency and we have to expand our public relations. Service such as blood pressure monitoring, diabetes detection, measles immunization programs, health fairs, etc. should be provided in the community.

When National Health Insurance becomes the law of the land, some form of proof of continuing competency will be required. If we do not establish our own guidelines, the Federal government will impose their will upon us once again.

Maryland is now ready to introduce legislation which will enable the Board of Pharmacy to establish guidelines, with a broad based advisory council from the profession, for the accreditation and adoption of course content. Your support for this bill and your continued efforts to demonstrate your professional ability, will bring back some of the lustre to the name "Pharmacist".

Be informed, be active, be vocal!

Drug Product Selection In Maryland

by

Paul Freiman*

NATIONAL HISTORY

The movement for repeal of the anti-substitution laws of the 1950's began nationally when the 1966 Committee on Legislation of the APhA arrived at a decision that the anti-substitution laws restrict the pharmacist in the exercise of his professional judgement. In 1970 the APhA House of Delegates adopted this as official policy and directed the Association to seek repeal of these laws.

Originally the Association supported the enactment of these laws, since they were designed to curb the problem of counterfeiting or unauthorized substitution of one drug entity for another. However, with the increased power of federal regulatory agencies the original problem for which these laws were created had been largely overcome. Their continuation had become increasingly detrimental to both the pharmacist and the health care consumer.

In 1971, the Policy Committee on Organizational Affairs proposed that the APhA encourage and assist state pharmaceutical associations seeking changes in their state laws. Thus, with the backing of the APhA, the move to repeal the anti-substitution laws began on a state by state basis.

EARLY HISTORY IN MARYLAND

In 1971 in view of the APhA policy, the executive unit of the Maryland Pharmaceutical Association adopted the position of attempting to repeal the anti-substitution laws in Maryland.

At the 1972 legislative session in Annapolis, delegates Torrey Brown, a physician member of the legislature, and Charles Doctor, a delegate from Montgomery County, agreed to sponsor repealing legislation of the anti-substitution laws. This bill, HB-573, became the center of much controversy, not only in the legislative body, but between various elements in Pharmacy; the MPhA and the medical society, and the Pharmaceutical Manufacturers' Association and the Association. On January 5, 1972, the author along with the Association's Executive Director, met with the Legislative Committee of the Medical and Chirurgical Faculty. Although not receiving their support at the time, we did notice among this group of physicians, a definite understanding of our reasons for support of this legislation. Unfortunately, their executive unit voted against support, so that at the time of the hearings on February 17, 1972 the MPhA stood virtually alone in support of HB-573. In opposition to our stand was not only the Medical Society and the manufacturers, but the Maryland Board of Pharmacy. The Maryland Society of Hospital Pharmacists and the School of Pharmacy spoke in support of the bill.

After the hearing, the Bill was assigned to committee where we believed that it was destined to die. However, much to our surprise the bill came out of the House committee with a favorable report. At this time we were contacted by the Medical Society to meet with their executive unit to discuss the DPS bill. At this meeting Dr. Ralph Shangraw of the School of Pharmacy, Nathan Gruz, myself and Delegate Brown were present. After the meeting, the Med Chi executive unit voted unanimously to support HB-573. After word was received in Annapolis of this support, the bill speedily passed the House and was sent to the Senate.

It was in the Senate that the pressure to defeat the bill really developed. Before passage through the House, the opponents believed that the opposition of the Medical Society in itself would lead to the bill's defeat. However, after the bill received the support of Med Chi, and passed through the House, the opponents, primarily the manufacturers, began a campaign for defeat of the bill. Letters began pouring into the Economic Affairs Committee from physicians, pharmacologists, and detail men. Under these pressures the Senate Committee released an amended bill, requiring that the pharmacist notify the doctor or physician in writing of the brand interchange. It also mandated the formation of a Formulary Committee to develop a list of drugs that could be used in brand interchange by the pharmacist. The necessity of notifying physicians made HB-573 virtually ineffective.

---

*Paul Freiman is a Commissioner on the Maryland Board of Pharmacy, Past President of the M.Ph.A. and Chairman of the Association's Consumer Affairs Committee.

In a shift of policy, the House of Delegates of the Medical Society overrode the endorsement the bill had received from their executive unit. A request was sent to the Governor for a veto of the bill. At the subsequent veto hearing, at which the MPhA stood virtually alone again, Governor Mandel upheld the bill and refused the veto.

THE FORMULARY COMMITTEE

In late 1972 the Secretary of Health appointed a Formulary Committee in order to implement the new law. Under the Chairmanship of Ms. Sue Fine and Kenneth Sumida the following members were appointed: Mr. Harry Bass, staff; Dr. Thomas Cullis, Med Chi; Mr. Paul Freiman, MPhA; Dr. Charles Kukimiam, FDA; Dr. Paul Tretman, MD pharmacologist of Johns Hopkins; Dr. David Ludman, pharmacologist University of Maryland; Dr. Harvey Minchew, University of Maryland School of Pharmacy; and Mr. Robert Snyder, MSHP.

After the meeting the Committee recommended that the antibiotics as a group be adopted for brand interchange since the FDA had begun requiring batch testing of all antibiotics produced and sold in the U.S. In addition, the official list of March 15, 1974 was expanded to include DOSS, Chloral Hydrate, and Meprobamate tablets. Early in its organization, the Formulary Committee realized the ineffectiveness of evaluating drugs on a manufacturer to manufacturer basis. The Committee realized it had neither the time, money or equipment to evaluate the thousands of drugs necessary under a positive formulary. The Formulary Committee effectively ceased operating after the list of March 1974 was published.

LEGISLATIVE ACTIVITY 1973-1977

At the 1973 Legislative session, an attempt was made to remove the notification requirement from the generic bill. This bill was subsequently defeated. In the 1975-76 legislative session, the bill was amended to remove the notification requirement for medical care prescriptions only; a move that many felt discriminated between those that could pay for their medication and those that could not.

Finally in 1976-1977 the move began in earnest to make Drug Products Selection realistic. Again at the urging of the MPhA, Delegate Brown introduced legislation for a negative formulary for interchangeable drugs, and for removal of the notification procedure. At this time, unlike in earlier years the MPhA did not stand alone. Consumer groups in large numbers began to lobby in support of HB-667. Notable among these were B.V.S. (Betterment for United Seniors), SAGE (Senior Alliance for Generic Equivalents), Maryland PIRG (Maryland Public Interest Research Group), plus many more smaller groups representing unions, churches, etc. . . . Even though the State Medical Society again refused to endorse the bill, the Baltimore Medical Society offered its support of the bill. Thus a united front in Annapolis insured the passage and enactment of the new D.P.S. bill.

THE NEW D.P.S. BILL

HB-667, which becomes effective on January 1, 1978, has the following key provisions:

1. The Department of Health shall establish a list of drugs for which drug product selection is prohibited. This formulary shall contain those drugs for which there is evidence of actual or potential bioinequivalency of *Therapeutic significance*.
2. The pharmacist shall pass on any savings in cost to the consumer.
3. The pharmacist shall notify the patient in writing if the drug dispensed is a generic equivalent. The necessity of notifying the physician has been removed.
4. The provisions do not apply if the physician indicates in his own writing or orally that the prescription is to be dispensed as written.

THE FUTURE OF D.P.S. IN MARYLAND

After many years of continuous effort over much opposition, the MPhA has achieved a D.P.S. bill that should meet the needs of both practitioners and patients. The establishment of a negative formulary will free the Formulary Committee from the necessity of endorsing each of the thousands of drugs available in any pharmacy. The Committee is charged to meet twice a year to review those drugs with potential problems, and to publish such lists. The pharmacist will be able to use his professional judgement in dispensing prescription drugs in all cases except the limited number of drugs appearing on the negative formulary.

In addition communication between the public and the pharmacist should be improved. The need to notify the patient of the use of a generic equivalent, should offer each pharmacist an opportunity to explain the role of the pharmacist in reducing the cost of health care. This in turn should lead the public to a greater respect for the professional role of the pharmacist.

The interest of the manufacturer in the professional role of the pharmacist has already been evidenced. Increased recognition of our responsibility in dispensing medications has been seen in the large number of manufacturers who are communicating with pharmacists on a personal basis as well as through the literature. The right of the pharmacist to select the drug product has become more and more evident to other health professionals as well.

In conclusion, the responsibility is yours. The existence of a Formulary Committee of experts in the field, in addition to the increased role of the FDA, should insure that continued high quality medications are dispensed in our state. It is hoped that the pharmacists of Maryland will recognize the opportunity presented to them by HB-667 and use it for the advancement of our profession and the benefit of the patient.

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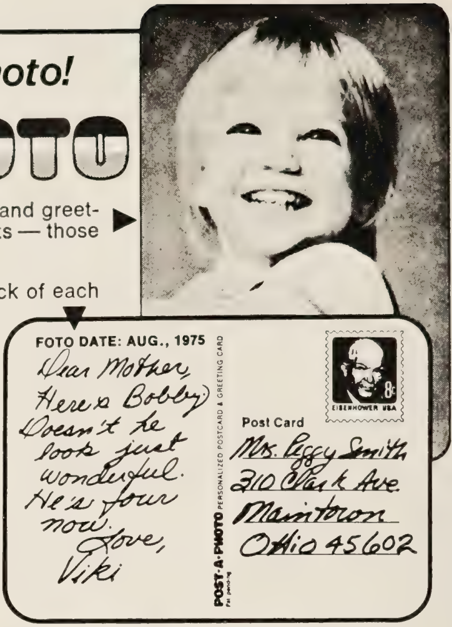

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wonderful.
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THE CALVERT DRUG COMPANY

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Are they lifting your shop?

by Thad L. Weber, Security Consultant, SK&F Laboratories

Thefts from businesses are estimated at the retail level to exceed 10 percent of gross sales and 30 to 40 percent of gross profits.

And the bad news is that the latest crime statistics report thefts rising almost 15% each year.

WORSE YET — THEFT OF CONTROLLED SUBSTANCES PUTS THE PHARMACIST IN TRIPLE JEOPARDY. Besides the loss of the drugs, he may lose the backbone of his business: the license to dispense controlled substances. And neither can be *insured!*

PHARMACY THEFT — "THE SHOPPER" The shoplifter loves pharmacies because they are really small department stores offering a wide variety of merchandise that's very resaleable. Some pros claim they're able to make $40,000 a year (tax-free) from pharmacies. Fences who receive stolen goods *train* their "pupils" in pharmacy theft because it's easy to steal from drugstores and it is extremely profitable. And neighborhood amateurs will sooner try their hand at pharmacy theft, because they believe the community-oriented pharmacist will not prosecute — if they should get caught with their hands in this cookie jar.

PHARMACY THEFT — THE EMPLOYEE. Some employees will not hesitate to steal cash, controlled substances, or other valuable merchandise, particularly if they believe they will not be prosecuted. Again the employee who comes from the neighborhood may be most tempted by this consideration, and to steal or to assist his friends by looking the other way while they filch merchandise.

WEAKNESSES THAT PERMIT THEFT. Since theft is the crime of taking something from you while you are open for business, we must conclude that theft is possible only when *you* aren't looking — or you can't see what is happening. Therefore, the conditions which permit theft include:

1. Placing small valuable merchandise within easy reach of the shopper.
2. Store layouts and displays which prevent employees from seeing the "shopper's" actions.
3. Poor hourskeeping.
4. Lack of supervision
5. Inadequate staffing.
6. Lack of controls of cash, controlled substances, and inventory of other valuable items.

TELLTALE SIGNS OF THEFT may include empty watch or camera cases, open blister packs, broken labels on controlled substance backup supply containers, unlocked display cases and lack of employee interest in discount purchases.

AN ANTI-THEFT POSTURE IS THE FOUNDATION FOR DEFENSE AGAINST SUCH CRIMES.

The pharmacist must first establish a policy to prosecute *anyone* committing a theft against him. He must advertise that shoplifters will be prosecuted. (Many associations furnish posters and placards for member use which are in compliance with local municipal statutes.) The pharmacist must also make his policy clear to all employees and new job applicants.

Other general deterrents to theft include:

1. Adequate staffing — to insure that at least one employee will always be on the floor to observe customer actions.
2. Security training — teaching employees to be alert to theft techniques, to greet all shoppers, to sound a code alert if suspicious situations develop, and to be wary of shopping bags and umbrellas that are placed on counter tops.
3. A policy that assures a designated employee is *in charge* of the store during the proprietor's absence.
4. Wall cases behind staffed showcases for displays of items such as cigarettes, film and razor blades.
5. Locked display cases for high value merchandise.
6. Storage of controlled substance items in drawers, safes, or racks inaccessible to customers and other employees.
7. Convex mirrors, one-way mirrors, closed circuit TV or automatic continual surveillance cameras properly located to deter would-be thieves.

As one pharmacist put it, "When you're doing more business but can't pay your bills, someone's stealing from you." Don't let that happen to you. Take action today!

Proposed Amendments to the Pharmacy Practices Act

Explanation:
CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
The following two bills have been pre-filed as amendments to the Pharmacy Practices Act. The bills were introduced by the Department of Health and Mental Hygiene. Please forward any comments you have on these bills to the M.Ph.A. Legislative Committee.

STATEMENT OF NEED

AN ACT CONCERNING:
Board of Pharmacy — Discipline

This bill will clarify and strengthen the procedures which are used by the Board of Pharmacy when taking disciplinary action against pharmacists.

Effective Date: July 1, 1978

BOARD OF PHARMACY — DISCIPLINE

ARTICLE 43 — Health
266A.

(a) The Board of Pharmacy is hereby granted power and authority either to reprimand a pharmacist or assistant pharmacist or to suspend or revoke his license for any reason as hereinafter set forth by a (unanimous) MAJORITY vote of the members of the Board, after a hearing upon not less than twenty (20) days' written notice to such pharmacist or assistant pharmacist. The notice shall be given by registered mail directed to his last known address and shall contain and state the date, hour and place of hearing, the specific charges against the pharmacist or assistant pharmacist upon which evidence will be heard by the Board, and such other information as the Board shall deem proper. At the hearing, the pharmacist or assistant pharmacist charged is entitled to be present in person and with counsel of his own choice, to hear and examine the evidence presented in support of the charges, and to cross-examine adverse witnesses, and thereafter to present evidence and witnesses, and to testify in his own defense.

[(c) The Board's power either to reprimand a pharmacist or assistant pharmacist or to suspend or revoke his license shall be for any of the following causes:

(1) Conviction of:

(i) A crime involving professional misconduct respecting the pharmacy or drug laws.

(ii) A crime involving the State Uniform Narcotic Drug Act or the federal narcotic laws.

(iii) His addiction to the use of morphine, cocaine, or narcotics of any kind.

(iv) His knowingly, intentionally, or fraudulently adulterating, or causing to be adulterated, drugs, chemicals or medicinal preparations.

(2) Procuring, or attempting to procure, registration in Maryland as a pharmacist for himself or another by knowingly making or causing to be made false representations to the Board.

(3) Adjudication as an incompetent under the provisions of Article 59 of this Code.

(4) Upon proof satisfactory to the Board of Pharmacy that a pharmacist or assistant pharmacist is guilty of grossly unprofessional conduct. The following acts on the part of a pharmacist or assistant pharmacist are hereby declared to constitute grossly unprofessional conduct:

(i) Paying rebates or entering into an agreement for payment of rebates to any physician, dentist or other person for the recommending of the services of any person.

(ii) The providing or causing to be provided to physician, dentist, veterinarian, or other medical practitioners, prescription blanks or forms bearing the pharmacists' or pharmacy's name, address or other means of identification.

(iii) The association by a pharmacist either as a partner, co-owner, or employee of a pharmacy, wholly or substantially owned by physician, dentist, veterinarian, or other medical practitioner or group thereof; but this paragraph shall not be construed or applied to have any retroactive effect or to apply to any such association existing on June 1, 1963, for such period as that association remains in continuous existence.

(iv) The advertising to the public by any means, in any form or through any media, the prices for prescriptions, dangerous or nonproprietary drugs, or fees for services relating thereto or any reference to the price of said drugs or prescriptions whether specifically or as a percentile of prevailing prices, or by the use of the terms "cut rate", "discount", "bargains", or terms of similar connotation: Provided, that the dissemination of information by a pharmacist, directly or indirectly, through any State-sponsored agency or any group recognized by the Maryland Commission on Aging, of special pricing and/or services, without identifying individual prescription drug items, to residents of the State of Maryland who have attained 60 years of age, shall not constitute unprofessional conduct within the meaning of this subtitle.

(v) The advertising or claiming to the public of professional superiority in the compounding or filling of prescriptions or in any manner implying professional superiority which may undermine public confidence in the ability, character and integrity of other pharmacists.]

(c) THE BOARD MAY WITHHOLD, DENY, REVOKE, SUSPEND OR REFUSE TO RENEW ANY LICENSE OF A PHARMACIST OR ISSUE A REPRIMAND FOR ANY OF THE CAUSES LISTED BELOW AS UNPROFESSIONAL CONDUCT:

(1) CONVICTION OF A CRIME INVOLVING MORAL TURPITUDE;

(2) CONVICTION OF A CRIME INVOLVING PROFESSIONAL MISCONDUCT RESPECTING THE PHARMACY LAWS.

(3) FRAUDULENT OR DECEITFUL PROCURING OR USE OF A PHARMACIST'S CERTIFICATE OF RENEWAL;

(4) ISSUANCE, PUBLICATION, BROADCAST, DISTRIBUTION OR ANY ADVERTISING WHICH TENDS TO DECEIVE OR TO DEFRAUD THE PUBLIC;

(5) AGREEING WITH AN AUTHORIZED PRACTITIONER FOR THE COMPOUNDING OR DISPENSING OF SECRET (CODED) FORMULA PRESCRIPTION;

(6) DIVISION OF FEES OR AGREEING TO SPLIT OR DIVIDE THE FEES RECEIVED FOR PROFESSIONAL SERVICES WITH AN AUTHORIZED PRESCRIBER;

(7) DISPENSING OR SALE OF ANY DRUG FOR WHICH A PRESCRIPTION IS REQUIRED WITHOUT FIRST HAVING RECEIVED FROM AN AUTHORIZED PRESCRIBER A PRESCRIPTION, WRITTEN OR ORAL, FOR SUCH DRUG;

(8) REFILLING A PRESCRIPTION FOR ANY DRUG FOR WHICH A PRESCRIPTION IS REQUIRED BY THE LAWS OF THIS STATE, UNLESS SUCH REFILLING IS AUTHORIZED BY THE PRESCRIBER EITHER IN THE ORIGINAL PRESCRIPTION OR BY ORAL ORDER;

(9) PROVIDING OR CAUSING TO BE PROVIDED TO AN AUTHORIZED PRACTITIONER, PRESCRIPTION BLANKS OR FORMS BEARING THE PHARMACIST'S OR PHARMACY'S NAME, ADDRESS OR OTHER MEANS OF IDENTIFICATION;

(10) ASSOCIATION BY A PHARMACIST EITHER AS A PARTNER, CO-OWNER, OR EMPLOYEE OF A PHARMACY, WHOLLY OR SUBSTANTIALLY OWNED BY AN AUTHORIZED PRESCRIBER OR GROUP THEREOF; BUT THIS PARAGRAPH SHALL NOT BE CONSTRUED OR APPLIED TO HAVE ANY RETROACTIVE EFFECT OR TO APPLY TO ANY SUCH ASSOCIATION EXISTING ON JULY 1, 1963, FOR SUCH PERIOD AS THAT ASSOCIATION REMAINS IN CONTINUOUS EXISTENCE;

(11) ADVERTISING OR CLAIMING TO THE PUBLIC OR PROFESSIONAL SUPERIORITY IN THE COMPOUNDING OR FILLING OF PRESCRIPTIONS OR IN ANY MANNER IMPLYING PROFESSIONAL SUPERIORITY WHICH UNDERMINES PUBLIC CONFIDENCE IN THE ABILITY, CHARACTER AND INTEGRITY OF OTHER PHARMACISTS;

(12) ADDICTION TO CONTROLLED DANGEROUS SUBSTANCES, HABITUAL DRUNKENNESS OR RENDERING PROFESSIONAL SERVICES WHEN INTOXICATED, OR UNDER THE INFLUENCE OF DRUGS WITH ABUSE POTENTIAL;

(13) AIDING OR ABETTING AN INDIVIDUAL TO ENGAGE IN THE PRACTICE OF PHARMACY WITHOUT A LICENSE, OR FALSELY USING THE TITLE OF PHARMACIST;

(14) WILLFULLY MAKING OR FILING FALSE REPORTS OR RECORDS IN HIS PRACTICE AS A PHARMACIST;

(15) WILLFULL OMISSION TO FILE OR RECORD OR WILLFULLY IMPEDING OR OBSTRUCTING A FILING OR RECORDING OR INDUCING ANOTHER PERSON TO OMIT TO FILE OR RECORD ANY REPORT REQUIRED BY LAW;

(16) PROFESSIONAL, PHYSICAL, OR MENTAL INCOMPETENCE.

(d) FOR THE PURPOSE OF THIS PROVISION, THE TERM CONVICTION SHALL INCLUDE A DETERMINATION OF GUILT, A GUILTY PLEA OR A PLEA OF NOLO CONTENDERE FOLLOWED BY A SENTENCE.

STATEMENT OF NEED

AN ACT CONCERNING:
Board of Pharmacy, Fees

The purpose of this bill is to eliminate reference to specific fees charged by the Board of Pharmacy. This will provide uniformity with other licensing statutes as well as enable the Board to raise their fees to cover the administrative and operating costs of the Board.

Effective Date: July 1, 1978

BOARD OF PHARMACY, FEES

ARTICLE 43 — Health
261.

(a) Any person of good moral character, who has had four years' actual experience in a pharmacy where physicians' prescriptions are daily compounded, or has served an internship program regulated by the Board and has attained the age of eighteen years, who shall present satisfactory evidence to the Maryland Board of Pharmacy that he or she has had at least four years standard high school training or its equivalent, and is a graduate of a school or college of pharmacy approved by the said Board or accredited by the American Council on

(Continued on Page 13)

"Facing" Up to Our Responsibilities

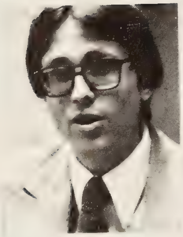
RAY HECKMAN

GORDON KNIGHT

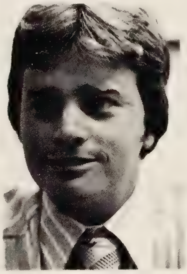
DENNIS CRAWFORD

MARY JO HALL

BILL HYSSONG


DON DUNPHY

VINCENT OLSON


DAVE WELLMAN

WILMA PRUDEN

BOB GITTINGS

TIM BRODERICK

LYON TYLER

DEAN SULLIVAN

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SK&F
a SmithKline company

(Continued from Page 11)

Pharmaceutical Education, as published in their official listing and who after examination by the said Board shall be by it deemed competent, shall be registered as a pharmacist and be given a certificate of such registration, provided, however, that not more than three years may be deducted from the four years of actual drugstore experience aforesaid, for the actual time of attendance at a reputable school or college of pharmacy or an internship program to be regulated by said Board be served. (Such a person shall make application to the secretary of said Board at least ten days before any stated meeting of the Board and shall pay to the said Board a fee of forty dollars.) TO APPLY FOR A LICENSE, AN APPLICANT SHALL SUBMIT TO THE BOARD AN APPLICATION IN THE FORM REQUIRED BY THE BOARD AND A REASONABLE APPLICATION FEE ESTABLISHED BY THE BOARD.

(c) Any person enrolling as a student of pharmacy in any school or college of pharmacy in this State shall, not later than thirty days after so enrolling, file with the secretary of the Maryland Board of Pharmacy, an application for registration as a student of pharmacy in which said application he shall be required to furnish such information as the Board may deem appropriate, and simultaneously with the filing of said application, shall pay to the Board a REASONABLE fee ESTABLISHED BY THE BOARD (of one dollar) all such students of pharmacy shall, at the beginning of any subsequent school or college year, submit to the said Board a sworn statement of any and all actual drugstore experience acquired during the preceding vacation months or an internship experience acquired during the preceding year as requested by the Board.

266B.

The Board of Pharmacy shall issue every two years a certificate of renewal in such form and style as it shall deem proper, to every licensed pharmacist who is entitled thereto and who makes application therefore, these certificates shall be secured every two years on or before the last day of September upon payment of a REASONABLE fee ESTABLISHED BY THE BOARD (of $15.00). Any pharmacist who fails for any reason to register or reregister hereunder within the time prescribed shall pay an additional fee (of $2.00) for each renewal period that he shall fail to register or reregister.

268.

(a) It shall be unlawful for any person, copartnership, association or corporation to operate, maintain, open or establish any pharmacy within this State without first having obtained a permit to do so from the Maryland Board of Pharmacy.

268.

(a) The application for such permit shall be made on a form to be prescribed by the said Board of Pharmacy and shall be accompanied by the (required) REASONABLE APPLICATION fee ESTABLISHED BY THE BOARD [of forty dollars ($40.00)]. For each renewal of a permit, [twenty dollars ($20.00) shall be paid as the fee to the Board of Pharmacy]. THE APPLICANT SHALL PAY A REASONABLE RENEWAL FEE ESTABLISHED BY THE BOARD.

(c) Application blanks for renewal permits shall be mailed by the Maryland Board of Pharmacy to each permittee on or before November 1st in each year, and if application for renewal is not made on or before the following 1st day of December, the existing permit shall lapse and become null and void on the date of its expiration, and no new permit will be granted except: (a) upon evidence satisfactory to the said Maryland Board of Pharmacy of good and sufficient grounds for the failure to file the application for renewal within the time prescribed; and (b) upon payment of a REASONABLE late fee [of $4.00] ESTABLISHED BY THE BOARD in addition to the renewal fee.

The said Maryland Board of Pharmacy shall make such rules and regulations, not inconsistent with law, as may be necessary to carry out the purposes and enforce the provisions of this section, and is hereby authorized, after due notice and opportunity for hearing, to revoke any permit when examination or inspection of the pharmacy shall disclose that such pharmacy is not being conducted according to law or is being so conducted as to endanger the public health or safety.

269.

No Drugs, or medicines, or toilet articles, or dentifrices, or cosmetics, shall be manufactured, made, produced, packed, packaged, or prepared within this State, except under the personal and immediate supervision of a registered pharmacist or such other persons as may be approved by the Maryland Board of Pharmacy after an investigation and a determination by the said Board that they are qualified by scientific or technical training and/or experience to perform such duties of supervision as may be necessary to protect the public health and safety; and no person shall manufacture, make, produce, pack, package or prepare any such articles without first obtaining a permit to do so from the Maryland Board of Pharmacy. Such permit shall be subject to such rules and regulations, with respect to sanitation and/or equipment, as the said Board of Pharmacy may from time to time adopt for the protection of the public health and safety.

The application for such permit shall be made on a form to be prescribed and furnished by the said Maryland Board of Pharmacy and shall be accompanied by [the required fee of five dollars ($5.00)] A REASONABLE FEE ESTABLISHED BY THE BOARD, which amount shall also be paid as the fee for each renewal of such

(Continued on Page 17)

When is a side effect a sign of effectiveness?

With Brethine, it is when the highly effective action of the drug affects skeletal muscle as well as bronchial smooth muscle, causing tremor in some patients.

It is important for you, the pharmacist, to realize that Brethine is a β_2-adrenergic agonist. The result of this action will be highly effective bronchodilation (β_2 receptors in bronchial smooth muscle) and, sometimes, tremor (β_2 receptors in skeletal muscle of particularly sensitive patients).

If you are asked about tremor, you should be aware that tremor is usually temporary, that it is a sign that Brethine is working and that easier breathing will continue even after the tremor subsides (usually in a week or two).

Patients should follow a bedtime, morning, and midafternoon dosage schedule to avoid overlapping dosage. They should minimize their intake of coffee and other caffeinated beverages and see their physician.

BRETHINE®
terbutaline sulfate

Brethine® brand of terbutaline sulfate
Tablets 5 mg., Tablets 2.5 mg. *Before prescribing or administering, please consult complete product information, a summary of which follows:*

Tablets contain 5 mg. (equivalent to 4.1 mg. of free base) or 2.5 mg. (equivalent to 2.05 mg. of free base) of Brethine, brand of terbutaline sulfate.

Indications: As a bronchodilator for bronchial asthma and for reversible bronchospasm which may occur in association with bronchitis and emphysema.

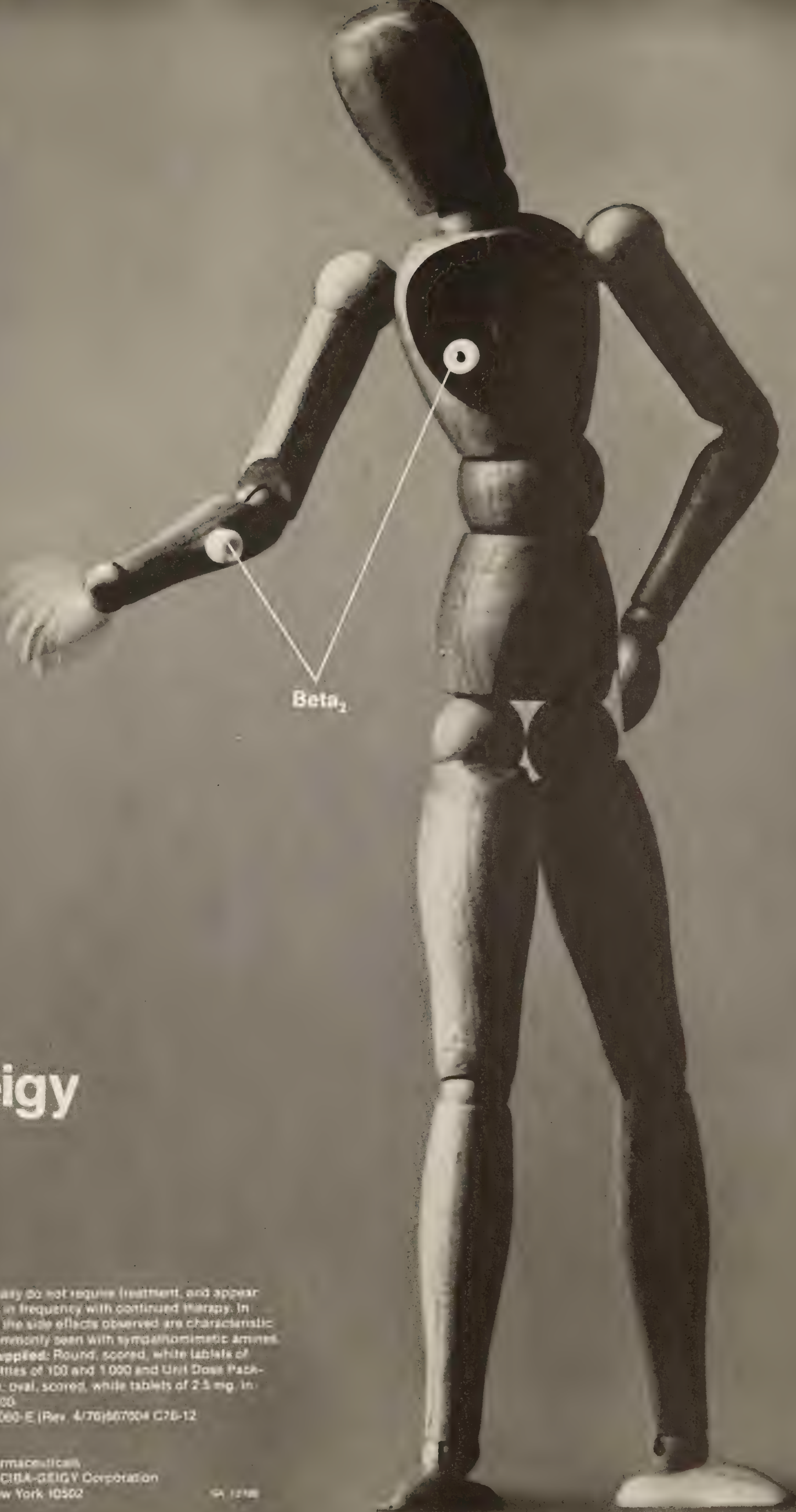
Contraindications: Known hypersensitivity to sympathomimetic amines.

Warnings: *Usage in Pregnancy:* The safety of the use of Brethine, brand of terbutaline sulfate, in human pregnancy has not been established. The use of the drug in pregnancy, lactation, or women of childbearing potential requires that the expected therapeutic benefit of the drug be weighed against its possible hazards to the mother or child.

Usage in Pediatrics: Brethine, brand of terbutaline sulfate, tablets are not presently recommended for children below the age of twelve years due to insufficient clinical data in this pediatric group.

Precautions: Brethine, brand of terbutaline sulfate, should be used with caution in patients with diabetes, hypertension, and hyperthyroidism. As with other sympathomimetic bronchodilator agents, Brethine, brand of terbutaline sulfate, should be administered cautiously to cardiac patients, especially those with associated arrhythmias. Although the concomitant use of Brethine, brand of terbutaline sulfate, with other sympathomimetic agents is not recommended, the use of an aerosol bronchodilator of the adrenergic stimulant type for the relief of an acute bronchospasm is not precluded in patients receiving chronic oral Brethine, brand of terbutaline sulfate, therapy.

Adverse Reactions: Commonly observed side effects include nervousness and tremor. Other reported reactions include headache, increased heart rate, palpitations, drowsiness, nausea, vomiting, and sweating. These reactions are generally transient in



Geigy

ature, usually do not require treatment, and appear
diminish in frequency with continued therapy. In
eneral, all the side effects observed are characteristic
those commonly seen with sympathomimetic amines.
How Supplied: Round, scored, white tablets of
mg. in bottles of 100 and 1,000 and Unit Dose Pack-
ges of 100; oval, scored, white tablets of 2.5 mg. in
ottles of 100.
) 98-146-060-E (Rev. 4/76)667004 C76-12

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rdsley, New York 10502 GA 1286

PPS
Paramount
PHOTO SERVICE

Legislation

(Continued from page 13)

permit. Separate applications shall be made and separate permits issued for each separate place of manufacture, making, production, packing, packaging or preparation.

Permits issued under the provisions of this section shall be exposed in a conspicuous place in the factory or place for which issued; such permits shall not be transferable; shall expire on the last day of December following the date of issue and shall be renewed annually.

Any person aggrieved by any rule or regulation promulgated by the said Board of Pharmacy under the provisions of this section shall be entitled to have his complaint set down for hearing by said Board. Requests for such hearings shall be made in writing and shall specify in detail the basis for the complaint, and the hearing shall be held within ten (10) days from the date of the receipt of said request by the said Board, unless postponed by mutual agreement.

The said Board shall have the power to make such rules and regulations with respect to the conduct of such hearings as may be necessary.

Any person aggrieved by an order of the said Board of Pharmacy, passed after such hearings, may appeal therefrom to the circuit court of the county in which such person resides, and if such person is a resident of Baltimore City, to the Circuit Court of Baltimore City or the Circuit Court No. 2 of Baltimore City and upon said appeal, the court shall hear and determine the issues raised thereby de novo.

Any person, firm or corporation violating any of the provisions of this section, and any permittee hereunder who shall violate any of the conditions of his permit or any of the rules or regulations adopted by the said Maryland Board of Pharmacy, in pursuance of the power hereby conferred, shall, upon conviction, be deemed guilty of a misdemeanor and fined not more than fifty ($50) dollars for each offense, and each and every day such violation continues shall constitute and separate and distinct offense; and, upon conviction of a permittee hereunder, his permit shall also forthwith be revoked and become null and void.

Nothing in this section shall be construed to apply to those operating retail pharmacies or drugstores.

[All permit fees collected under the provisions of this section shall be used by the Maryland Board of Pharmacy, so far as may be necessary, for the enforcement of the provisions of this subtitle.]

270A.

(b) The application for such permit shall be made on a form to be prescribed and furnished by the Board and shall be accompanied by [the required fee of $10.00] A REASONABLE FEE ESTABLISHED BY THE BOARD which amount shall also be paid as the fee for each renewal of such permit.

INSPECTION REPORT FORMAT CHANGED SLIGHTLY SINCE PUBLISHED IN JOURNAL.

The MARYLAND PHARMACIST article on Drug Inspections in the October issue included a reproduction of the Inspection report form which has been changed since press date. The new form is in three parts so the pharmacist receives an exact duplicate of the report which goes in his permanent record. The new form eliminates the yes, no column. An X in the single column indicates non compliance. The first item (25) is now numbered (24a). No space was left in the article to record the location of (36) poison register and (37) syringe book but there is adequate margin space for this purpose.

Some violations being noted frequently in recent inspections include: not dating invoices for Schedule III/IV/V items upon receipt of invoice (the date imprinted by the supplier is not acceptable since it may not be date of receipt); Red C not in *lower right hand corner, stamped one inch high;* not bringing forward *as new subscriptions* physicians' authorizations for additional refills on permissible scheduled items; outdated products in cosmetic area; quantity and date received not filled in on pharmacy copy of Schedule II order forms.

Pharmacies short on audit of Scheduled items are required to provide a written explanation of the shortage for Department to evaluate. Audits are expected to be performed in each pharmacy at least once a year. Pharmacies that are not in compliance on the same item on two inspections may be called to an informal hearing to discuss the problem. Repeat violations are subject to formal hearing and possible action. The Division of Drug Control reports that pharmacy inspections are showing much better compliance records as educational programs have made pharmacists more aware of the bookkeeping expected of them. MPhA position has been to work with Drug Control while attempting to have laws which have no effect on health and welfare of the patient changed.

calendar

Dec. 1 (Thurs.) — MSHP Meeting, St. Joseph's Hospital

Jan. 7-15 — MPhA TRIP TO MARTINIQUE — Enjoy the warm company and weather

Feb. 12 (Sun.) — BMPA Annual Installation Dinner Dance

Mar. 5 (Sun.) — Swain Seminar

May 13-18 — APhA Convention — Montreal — look for MPhA Charter

The Consumer's Point of View

by

Estelle Cohen*

Presented at the
Simon Solomon Seminar
October 27, 1977

Personally, I prefer a luncheon speaker who adds a generous portion of whipped cream to dessert, but here I am cast in the role of critic and that is not at all sweet.

The topic assigned to me is "What is the Patient's View of the Pharmacist?".

Today, patients, the public, you and I; we are all cynical about the integrity and good intentions of those in government, business and the professions and therefore, there is a degree of cynicism directed toward pharmacists in our society.

The public has read and heard about fraud on the part of the physician and the pharmacist in the medicare and medicaid programs in nursing homes scandal and this unfortunate behavior of the few casts a long shadow over the rest.

In addition to this, patients no longer feel that having a prescription filled is a complex or mysterious process. In spite of only wanting a qualified pharmacist to fill his prescription, the patient is often satisfied to make his purchase on the basis of price. He is ignorant of the real health related service you offer. To most of the public the "service" the pharmacist provides means that you will deliver the prescription or fill it within a short period of time, or stay open on Sundays. He is ignorant that the fund of knowledge you possess gives you the wherewithal to instruct him, to advise him, and to protect him in the serious, arcane business of drug compliance. He is also ignorant of how potentially dangerous and sometimes deadly taking drugs is in the course of trying to feel better or to stay well.

I respectfully submit that this generation's ignorance of the totality of the role the pharmacist is educated to assume, will widen and deepen, unless you make your clientele aware that you are a vital link in the delivery of health care — and to what extent you are vital.

Frequently, I am asked why the consumer groups appear to primarily zero in on the pharmacist. This makes some of you touchy. I would like to address the subject of consumer behavior in an attempt to change "touchiness" to "understanding" which is a much more productive response.

Essentially the consumer is enraged about the high cost of health care. He must certainly be aware that every facet of medical care has taken quantum leaps in price in recent years, and yet, he frequently makes you the focal point of his wrath. He demands price posting, advertising, and things that are so annoying to some of you.

I agree that this imbalance in blame is not quite reasonable and the consumer should certainly spread his wrath more equitably if only for his own sake.

From my vantage point, I see several other overall reasons for this less than desirable consumer behavior.

First:

You are the most visible, accessible deliverer of health care on whom we the consumer can release our frustration.

You are plentiful enough so that we the public do not fear that if one of you displeases us, that we must compromise. Usually, another pharmacist is near by.

Second:

There are times when we pick up our prescription or we purchase over the counter drugs when we do not feel well ourselves or we are preoccupied with concern for someone in our care whom we love.

Right away our thinking is colored by our emotional state and the high cost of the drug we purchase seems yet another stroke of our tough luck. And so we get angry with you, seeing you as responsible for the high drug price, however illogical and unwarranted this may be.

Also, because your product seriously affects our physical well being, any mistake you make in price or count, or dispensing the wrong drug or in personal rapport with the patient or in your appearance, chafes us far more than a similar mistake made by the grocer, or clothing store or camera shop salespersons.

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*Estelle Cohen is the Consumer Commissioner on the Maryland Board of Pharmacy.

Third:

You are easier to take on than the drug manufacturer and the drug manufacturer certainly bears a greater part of the responsibility for the high price of drugs, in my opinion, than does the pharmacist. But, you are here, and the manufacturer is remote and he is very busy publicizing what he has done and is busy doing for the consumer. You are also easier to take on than the physician. There is plenty of serious criticism and emotional hostility directed toward doctors today; however, the physician is in small supply relative to the population. He maintains a mystique about the practice of medicine that holds off consumer attempts to organize and to approach the physician. Today, consumer displeasure with physicians is becoming more vocal and will possibly impact in government action.

At times, consumer complaints are misdirected. For example: I have heard the pharmacist faulted for labeling medicine "take as directed" when of course this complaint should be communicated to the prescribing doctor.

Safety caps annoy patients! They are not always aware that there is a choice about having them. Nobody tells them.

Consumers sometimes complain that they are not given priority consideration when they feel they have emergency prescriptions and therefore wait their turn impatiently.

Sometimes you patients have been refused a portion of their prescription when they have lacked enough money for the entire prescription.

Perhaps taking part of the medication would be more dangerous than taking none — but they do not know this — if they are not told.

Estelle Cohen

Consumers lament the fact that pharmacies are by and large uncomfortable. There is no place to sit if you wish to wait for a prescription in many pharmacies.

To borrow an expression from your former President and Chairman of the Board, Mel Rubin, "There is a flip side, too." There are positive, admirable comments made to me regarding individual pharmacists. Some of you have built up a community of loyal customers. Surely you have noticed that when you enjoy the confidence and respect of the patient, it is then that price becomes secondary — he will go out of his way to come to you.

The more you trouble yourself to communicate your interest to the consumer, the more you reinforce his confidence in you.

As you serve him, you serve yourself. For example, each time the customer takes an over-the-counter drug off of your shelf, he is taking a chance on his health off of your shelf because he is ill informed in your field of expertise. Let him know that over-the-counter drugs are in your domain of proficiency and you are interested in his use of them.

Do you know that many consumers who complain and demand action in channels open to them are nevertheless kittens while in your pharmacy? Often even if we are having a prescription filled, we don't see or speak to you and we do not feel all that comfortable about taking your time to talk about over-the-counter drugs or other drug related questions. This can be true even when you are visible. There is nothing inviting us to communicate with you.

With few exceptions — when you ask the consumer to give you his mental picture of a pharmacy — the pharmacy department is not at all imposing or important. It is sort of mixed in with everything else.

Now I ask, should we label consumer interests hazardous to your health?

Let's review consumer impact in your field.

During the 1960's our economy was going full steam. Senator Edward Kennedy said our entire population has a right to health care — but it is not financially possible for all Americans to exercise this right. The public by and large enthusiastically endorsed programs of social progress.

In 1965 corrective measures were taken and the Medicare-Medicaid programs were born. A direct result of this was that millions of dollars were poured into the medical system. Consumer demands for drugs among other things grew rapidly.

For some pharmacists this transfusion of dollars for drugs had to have been a good healthy by-product of consumer activity.

It is those consumers not benefiting from these programs that pick up the tab of Medicare-Medicaid through higher taxes and higher costs of medical care. Some of you, I know, are not happy with these programs at present.

Health care legislation appears to have powerful advantages and equally powerful disadvantages for all concerned.

(Continued on Page 21)

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*Ind. Market Research

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Consumer's Viewpoint

(Continued from Page 19)

Consumer groups are staying abreast of the various national health programs that are afloat for deliberation in Congress — just as I am sure you are. Ideally, an equitable National Health Plan will emerge — one that the taxpayer, suppliers and the recipients of health care will profit from.

On the state level, consumer activism had a great deal to do with the recent passage of the generic substitution bill. This law should work to the benefit of pharmacist as well as consumer.

Need I mention price posters? Whatever the courts do decide about their constitutionality, I suggest that you publicize your prices in your pharmacies to demonstrate to the public your openness in conducting the business aspect of pharmacy. You are participating in the great American marketplace where the price is very important to the consumer.

An argument against price posting is that most people do not read the posters and this argument misses the point. Any aloofness you show to reasonable concerns of the consumer builds walls instead of bridges. It must not be easy to wear two hats all of the time, but those of you who earn your livelihood in retail pharmacies do. You are at once — a professional and a businessman.

It is the professional in you that resents price posting as well as advertising. But advertising of itself is not demeaning. Properly handled it serves as a vehicle to give the public information.

The business person in you should recognize advertising as a healthy aspect of competition in our society. Your advertising should educate the public as to the professional service you offer.

It should reflect your high ethical standards. You play a profoundly important role in society — the respect you have for yourself and your profession should be reflected in your ads. You are only responsible for your own advertisements, though, I am aware other advertisements annoy you.

My husband, a businessman, has mentioned that he thinks the people who most carefully read his advertisements are his competitors.

My association with pharmacists makes me think that is true for you too.

As to the future relationship between the consumer and the pharmacists — all signals point to the pharmacist becoming more visible and more active in patient health care as he certainly should.

Conferences I have been privileged to attend sponsored by medical societies, pharmacy societies, drug manufacturers and the Food and Drug Administration have devoted much of their time to a discussion of the growing problem of incorrect drug compliance.

Patient package inserts are not considered an adequate source of drug information to patients in light of the fact that 40% of our population is functionally illiterate.

Therefore, opinion has it that a mantle of responsibility for counseling patients on drug compliance falls on your shoulders.

It is predicted that pharmacists will play a more active role in the selection of drugs for patients in the future, as some pharmacists are already doing in a few institutions at present.

The Commissioners of the Maryland Board of Pharmacy have recently formed a committee of representatives of health professions, educators, media, consumer representatives. We have two objectives.

The first is, to utilize the media and other sources to harp on the patient's own responsibility in taking drugs.

Our second goal is to have physician, pharmacist and the public in agreement about the growing responsibility of the pharmacist in health care, and to encourage personal interaction on the subject of drugs with the patient and the physician to be reinforced by personal interaction with the patient and pharmacist. We want to publicize your expertise and allow you to put your own good judgement into greater play in your role.

I hope you will work with us in expanding your role in health care and making use of your fund of knowledge to the greater benefit of the consumer.

I am told that computers will be cheaper in the next few years. They can prove to be a great adjunct to the practice of pharmacy, allowing you the time to open your practice to patient profiles, to counseling patients.

You are a rich resource for society and no part of you should be wasted.

President Signs Minimum Wage Bill

President Carter signed into law the Fair Labor Standards Amendments of 1977 which will increase the minimum wage level from the present $2.30 an hour to $3.35 by 1981.

In brief, the new law establishes the following minimum wage rates: $2.65 an hour effective January 1, 1978; $2.90 an hour effective January 1, 1979; $3.10 an hour effective January 1, 1980; and $3.35 an hour effective January 1, 1981. The law also provides for an increased exemption for small business based on gross sales volume which will be hiked from $250,000 to $362,000 by 1981. Additionally, the tip credit will be decreased from 50 percent to 40 percent from 1978 to 1981. The controversial indexing provision which would have tied future minimum wage increases to the average hourly earnings in manufacturing was dropped from the legislation while another section has been added which establishes a special study commission on the minimum wage.

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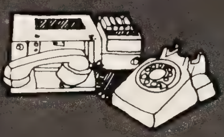
Electronic order entry Terminal for in-store use. It's lightweight, portable and enables you to order 200 line items in less than one minute. Transmits over telephone. Operational 24 hours a day . . . call at your convenience.



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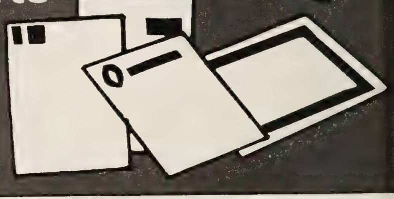

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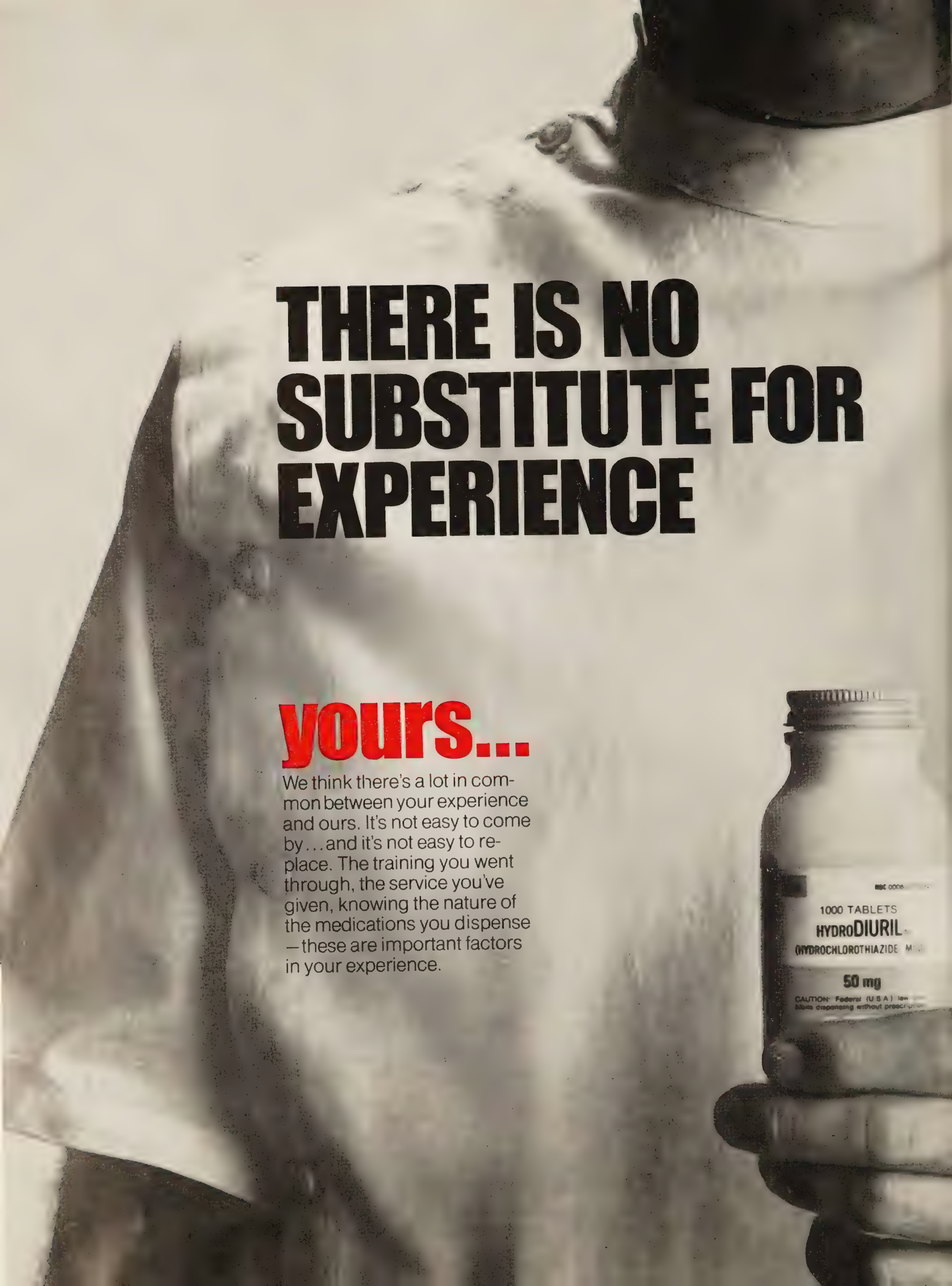
On November 10th, BMPA held its annual meeting at the Quality Inn in Pikesville. Over 100 pharmacists heard a presentation on Compliance Inspections from *(left to right)* Charles Tregoe, Drug Control; Ralph Quarles, President of the Board of Pharmacy; Milton Sappe, President BMPA; Rick Jarvis, Drug Enforcement Administration; and Irv Myers, Chief of Drug Inspectors.

BMPA Installs Officers at Annual Meeting

Milton Sappe *(left)* receives the gavel of the Baltimore Metropolitan Pharmaceutical Association from Vic Morgenroth *(right)* who installed the new officers at the annual meeting. Milton succeeds Stan Yaffe as President of the BMPA.

Photos courtesy of Paramount Photo Service

The Officers and Executive Committee members of the BMPA take the oath of office. *(left to right)* Milton Sappe, Bernard White *(partially hidden)*, Norma Schapiro, Frank Marinelli, David Banta, Samuel Lichter, Stanley Yaffe, Victor Morgenroth, Marvin Friedman, Charles Spigelmire, Elwin Alpern, James Culp, Jr., David Oken, George Voxakis, and Joseph Loetell.


1000 TABLETS
HYDRODIURIL
(HYDROCHLOROTHIAZIDE
50 mg
CAUTION: Federal (U.S.A.) law

THERE IS NO SUBSTITUTE FOR EXPERIENCE

yours...

We think there's a lot in common between your experience and ours. It's not easy to come by...and it's not easy to replace. The training you went through, the service you've given, knowing the nature of the medications you dispense—these are important factors in your experience.

...ours

The quality research that we contributed to the development of HydroDIURIL, the quality control that has marked its many years of production —this, too, is the kind of experience we believe you can appreciate. When it comes to HydroDIURIL, we hope you will make no substitutions for the experience that can have no substitute.

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia and possibly other adverse reactions that have occurred in adults.
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in postsympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.
Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.
Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.
Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.
How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.
For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6HD05(528)

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LETTERS

AM I SCARED?

Dear Sir:

You bet I am.

During the last 18 months, I have suffered through 2 break-ins and 3 armed holdups.

During the last holdup my two daughters (who were working with me in the store that night) and a customer and I were forced at gunpoint, to lie down on the floor, while the robbers made their escape.

Should I close earlier? Should I sell the store and move to a safer location, or should I have an armed guard for my protection at night? Should I stop carrying all narcotics in my store?

I don't know what the answers are, but I sure would welcome any suggestions to make my life safer.

Thank you,

Donald Dagold
Watermont Pharmacy
Ellicott City, Maryland
21043

SAPhA Regional News

(left to right) Marc Fry, SAPhA Regional Coordinator; Ruth Sammel, SAPhA Regional Secretary; and Chad Rolfe, SAPhA Regional Delegate.

This year's Annual Convention of the Student American Pharmacy Association, Region II, was held at the Benjamin Franklin Hotel in Philadelphia on October 28, 29 and 30th. The Region consists of the schools of pharmacy in Pennsylvania, New Jersey, Maryland, West Virginia and the District of Columbia. The University of Maryland sent nine representatives.

The program began with a debate on the Pharm.D. degree vs the B.S. degree in Pharmacy. We attended workshops on IV admixtures, folk medicine, cardiopulmonary resuscitation and contact lenses.

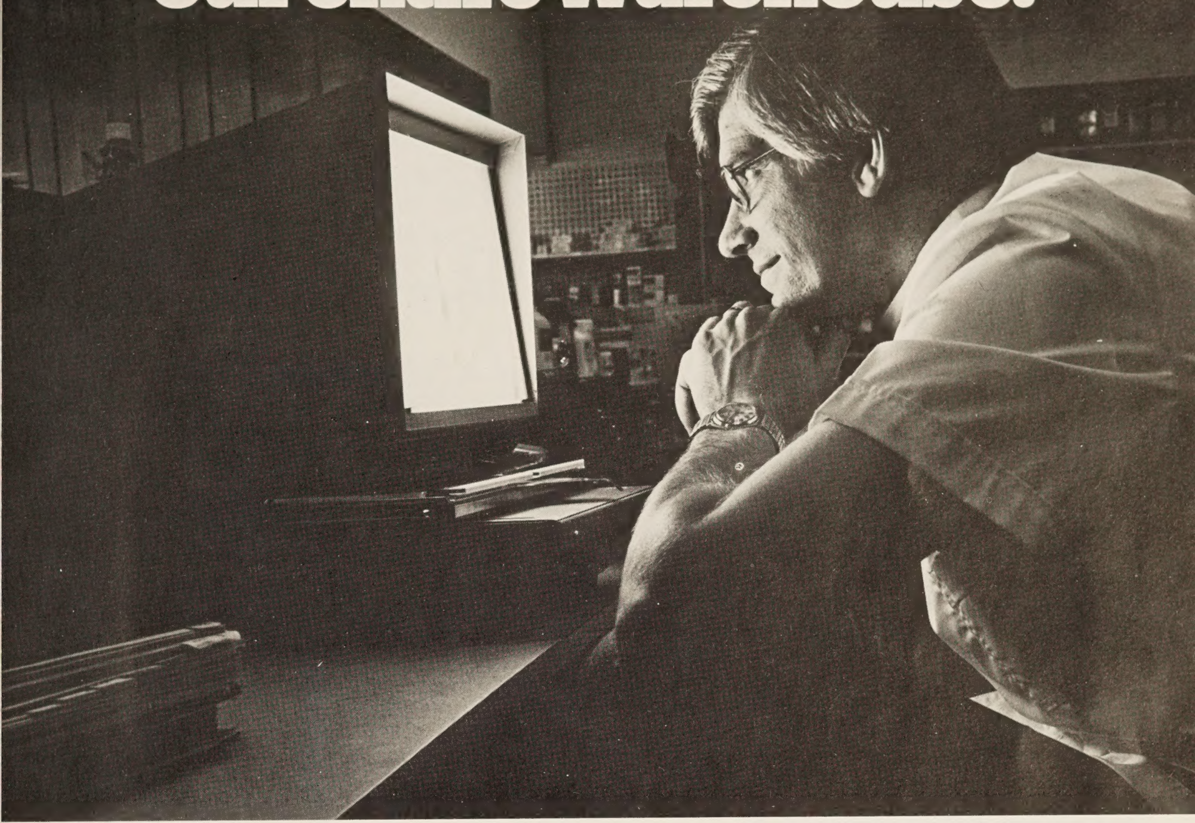
One of the highlights of the weekend was the Saturday afternoon meeting on Careers in Pharmacy when four members of Maryland's delegation dressed up in our Halloween costumes and came in late.

The business meeting took place on Sunday. We voted on various resolutions which we will now present to the SAPhA National in Montreal. The elections of new officers took place in which Ruth Sammel's last minute decision to run for Region Secretary paid off. Other officers elected were Marc Fry, Regional Coordinator and Chad Rolfe as Regional Delegate.

Photo courtesy of
Paramount Photo Service

On November 15, 1977, the Industrial Relations Committee held a special meeting at the Friendship International Hotel on the subject of "standardizing package labeling" which was hosted by the Pharmaceutical Manufacturers' Association. Among those who participated were *(left to right)* Richard Parker, M.Ph.A. President; David Banta, M.Ph.A. Executive Director; John Ruggiero, Assistant Vice President PMA; H. C. Welch, Manager for Packaging Development at Upjohn; Carl B. Burnside, Packaging Advisor Market Research Division for Lilly; and George Stevenson, Chairman M.Ph.A. Industrial Relations Committee.

Now showing at your counter: our entire warehouse.



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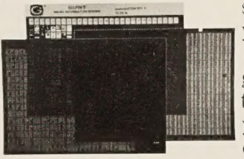
If you know exactly what we have in stock at any given moment and exactly what it costs—and if you know that we can get it to you the next day—you can turn our warehouse into your warehouse. You won't have to waste valuable storage space keeping overages on hand. You won't have to worry about items carrying last month's lower prices. You won't have to recommend to your customers that they shop elsewhere for the products they need. And most important, you'll be able to get a jump on the competition on special promotion items.



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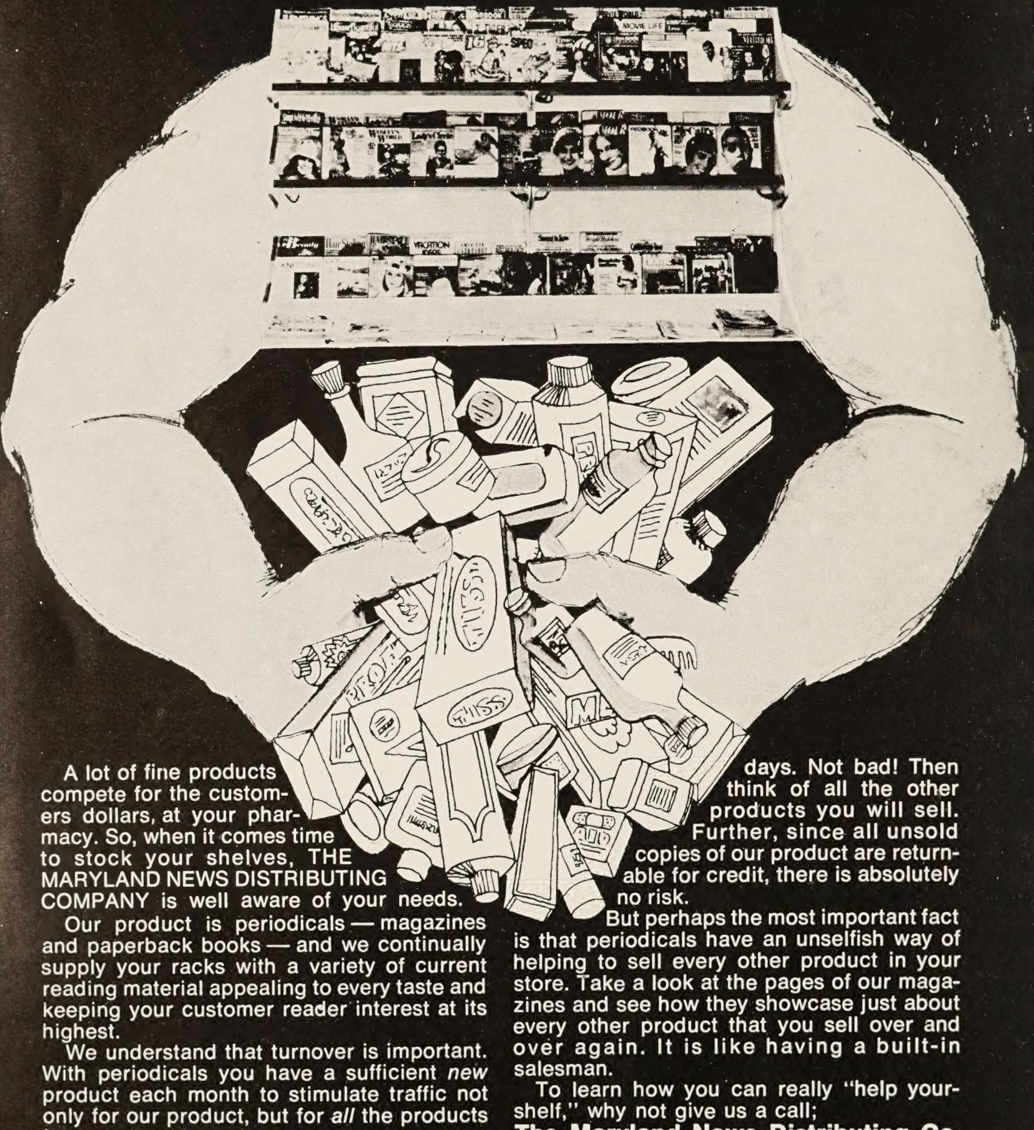

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